Health Improvement Plan

Public Health Action for the First Decade 2000-2010

Executive Summary

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A Product of:

HEALTHY MARYLAND
PROJECT 2010

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MARYLAND'S HEALTH IMPROVEMENT PLAN

TABLE OF CONTENTS

I. HEALTHY MARYLAND OVERVIEW

FOREWORD

This report, Maryland's first Health Improvement Plan (HIP), was developed to promote the public health agenda for Maryland as the 21st Century begins. It is a consensus document, formulated with input from health care consumers, providers, and other advocates in the public and private sectors around the state. A detailed list of contributors is provided in the Appendix.

Although this Plan includes a broad array of topics of public health concern, it is not an exhaustive list. Rather it examines and presents recommendations for a focused list of priorities, linked to the priority areas included in the national Healthy People 2010 report. A variety of quantitative and qualitative methods were used by focus groups convened to select the topics discussed in this Plan.

Priority subjects in 17 different focus areas are presented at the state level in this report. A similar array of priority subjects are presented from each of Maryland's 23 counties and Baltimore City with at least one topic from each jurisdiction. However, there are many additional areas of priority concern in these jurisdictions and statewide. The table on page 6 provides a summary listing of state and local priorities discussed in this HIP. Additionally, this table includes areas of priority concern which the local jurisdictions identified in their annual health plans, as well as others that were identified within the plan development process for the modules included in this Plan.

Data used to select these priority areas were primarily from 1997 to 1998. As new assessments are completed with updated facts and figures, these priorities may change. Consequently, every effort will be made to revise the HIP, at regular intervals, to reflect the changing needs of Maryland communities and its residents.

In addition to contributing one or more modules to this report, several local health departments have also published their own Health Improvement Plans or other strategic planning documents. These reports provide a more detailed discussion of local priorities and the process used to identify them.

MAJOR FINDINGS FROM MARYLAND'S FIRST HEALTH IMPROVEMENT PLAN

As the 21st century opens, Maryland is home to slightly more than 5 million people. The overwhelming majority of these people are relatively young, less than 65 years of age. However, the elderly population, ages 65 years and over, continues to grow and was almost 12 percent of the total population in 1998. Maryland is home to a diverse ethnic population; African Americans, at almost 28 percent of the entire statewide population in 1998, constitute the major minority group. This proportion is decreasing as the number of other ethnic minorities continues to climb.

A variety of health status information exists to gauge the health of this population. We continue to assess health primarily with mortality, or death, data. An examination of available statistics indicates that the ten leading causes of death in 1998, at the end of the last century, were:

Leading Causes of Death in Maryland, 1998

Rank:	Cause:
1	Heart Disease
2	Cancer
3	Cerebrovascular disease (stroke and related circulatory system conditions)
4	COPD (chronic obstructive pulmonary disease)
5	Pneumonia and Influenza
6	Diabetes
7	Unintentional Injury (with motor vehicle injuries accounting for almost half)
8	Septicemia (infection of the blood)
9	Homicide
10	HIV (human immunodeficiency virus)

Source: Maryland Vital Statistics, 1998

Findings from extensive biomedical research during the past century indicate that the causes of many of the health problems that contribute to these deaths can be prevented and/or greatly controlled. Healthy People 2010 is based on this premise and Maryland's Project 2010 joins the national effort. To assist in charting a focused preventive health course, a variety of mortality and morbidity data, other health status information, and information on health care resources, including the public health workforce, were examined to identify areas for priority attention for Maryland's first Health Improvement Plan. At the state level, 17 areas were selected for priority attention. At the local level, a wide variety of health problems within these 17 areas and also in other areas, were selected for priority attention.

A summary of state and local priorities is provided in the table on the next page. An analysis of the overlapping areas yields the ranking among the priorities as detailed below:

Top Ten Focus Areas Addressed or Listed as Priorities in the Maryland Health Improvement Plan for 2010:

Priority Rank	Focus Areas
1	Child & Adolescent Health
2	Substance Abuse
3	Cancer
4	Access to Health Care
5	Injury and Violence and Maternal & Infant Health (tied for fifth)
6	Tobacco
7	Immunization and Infectious Disease and Mental Health (tied for seventh)
8	Heart Disease and Stroke, HIV, and Sexually Transmitted Diseases (tied for eighth)
9	Public Health Infrastructure
10	Environmental Health, Family Planning, and Oral Health (tied for tenth)

Although this list provides some insight into the leading areas of concern among those striving to improve the health of Marylanders and the communities in which they live, it only provides a qualified view. First, the list is a summary. A list of priorities for any one of the 24 local jurisdictions may vary greatly. Second, within the listed priorities, there are a wide variety of problems that require attention in order to improve specific problems at the state and/or local levels. Available resources and political will also impact efforts and outcomes. Finally, it is important to note that health status is not static; for any specific measure, there are ongoing changes as the health status improves or problems worsen. Continual monitoring and periodic re-examinations are essential in order to chart a timely and appropriate course to improve and promote Maryland's health.

STATEWIDE AND LOCAL PRIORITY AREAS – 2000

DHMH Priority Areas / County	Access to Health Care	Cancer	Cardiovascular Disease & Stroke	Child & Adolescent Health	Chronic Diseases	Environmental Health	Family Planning	HIV	Immunizations & Infectious Diseases	Injury & Violence Prevention	Maternal & Infant Health	Mental Health	Oral Health	Public Health Infrastructure	Sexually Transmitted Diseases	Substance Abuse	Tobacco Use	Other	Totals
Allegany	✔	*	*	*	*		*	*	*		*	*	✔	*	*	*	*	*	16
Anne Arundel	✔	*		*	*	*		*	*	*	*				*	*	*	*	13
Baltimore	✔			*							*							*	4
Calvert	*			✔		*	*			*		*				*	*	*	9
Caroline				✔				*	*			*			*				5
Carroll	✔	*	*		*	*				*		*	✔			✔		*	10
Cecil		✔	✔				*	*	*	*					*	*	*		9
Charles		*	*	*		*		*		*	✔	*		*		*		*	11
Dorchester		*	*	*			*	*	*	*	*			*	*		✔		11
Frederick	*	*		*								*	✔	*		*		*	8
Garrett			*	*			*			*			✔			*	*		7
Harford	*	*	*	*	*	*	*			*		*		✔	*	✔	*		13
Howard	*			✔	✔	*								*				*	6
Kent				*				*	*					*	✔				5
Montgomery	*	*		*	*			*		*	✔		*			*		*	10
Prince George's	*						*	*	*		✔	*		✔	*	*			9
Queen Anne's		*		*												✔		*	4
Somerset		*		*							*					*	✔		5
St. Mary's	*	*	*						*	*	*		✔						7
Talbot		*		*		*	*		*	✔	*	*	*			*	*	*	12
Washington	*	*	*	*	*			*	✔	*	*	*	*			*	*	*	14
Wicomico		*	*	*							✔			*		✔	*	*	7
Worcester	*	*		*					*	*	*	✔		*	*	*	*	*	12
Baltimore City	✔	*		*		*									*	*			6
Totals	14	17	10	20	7	8	8	10	11	13	13	11	8	9	10	18	12	14	**213**

Note:

Statewide Priorities:

Each of the seventeen focus areas listed in first row is addressed as a statewide priority in the HIP.

Local Priorities:

✔ An issue of priority concern within this focus area is the topic of a module included in the HIP for this jurisdiction.

* This focus area was identified as an additional area of priority concern during the HIP development process and/or overlaps with an area identified as a priority concern in this jurisdiction's FY00 Annual Plan for the Core Public Health Funding Program. "Other" includes topics that do not fit in one of the featured priority areas.

INTRODUCTION TO THE HEALTH IMPROVEMENT PLANNING PROCESS IN MARYLAND

The Maryland Health Improvement Plan (HIP) is a product of Healthy Maryland Project 2010, Maryland's response to the nationwide Healthy People initiative.

What is a Health Improvement Plan?

A health improvement plan is a document that provides a framework and consensus-based recommendations for improving the health of the residents of a state or local community. In a time when new health information is presented and refuted daily and budgets revolve around the latest health threat, a health improvement plan provides insight into health solutions for the long term. It presents a road map for how to achieve health for all. A positive health status provides the foundation for success in health and business. It is a foundation for a healthy economy.

What is Healthy People?

Healthy People is the name of the objective-setting process for health promotion for the nation. It is further described in the Healthy People Overview included in the full HIP report.

What is Healthy Maryland Project 2010?

Maryland's response to the national Healthy People 2010 initiative was launched in July of 1998 to unite stakeholders from all segments of the community in a collaborative effort to protect and improve the health of all Maryland residents.

How was the Maryland Health Improvement Plan developed?

A wide range of government and non-government representatives participated in the development of Maryland's Health Improvement Plan. The Healthy Maryland Project 2010 steering committee is made up of over 100 representatives from state and local health departments, academia, medicine and the non-profit, faith, and business communities. The steering committee approved the overall concept of the planned report. The planning committee was instrumental in overseeing the year-long development process. In the Fall of 1999, State health program directors and local health department personnel were given guidance for development of each module by the Office of Health Policy at the Maryland Department of Health and Mental Hygiene. Input from outside government was required for each module through focus groups or an existing process. Draft modules were compiled in the Spring of 2000, and a working draft was distributed for public comment in August 2000. At each stage, care was taken to include community input for the purpose of ensuring a consensus-based plan.

What is contained in the Maryland Health Improvement Plan?

The Maryland Health Improvement Plan sets Maryland-specific objectives for improving the health of Marylanders. In addition, the HIP presents action steps for how to achieve these objectives. The focus areas presented in the document, however, do not make a complete list of the health

problems facing Maryland's citizens. The focus areas included in the document were chosen by consulting four sources: the 28 national focus areas, the outcome priorities of the 1999 Healthy Maryland Project 2010 Summit, the priorities presented in the 24 local health departments' annual plans for FY2001, and a survey of the Healthy Maryland Project 2010 Steering Committee. The 17 focus areas make up the "Statewide Focus Areas" section of the document. At least one topic of concern is addressed in each focus area.

Each local jurisdiction has chosen one or more focus areas to highlight in the HIP. These do not necessarily represent the highest priority health issue for that jurisdiction, but are areas of concern. The modules from Maryland's 24 local jurisdictions make up the "Local Focus Areas" section of the document. The appendices contain the names of all the contributors.

How will the Maryland Health Improvement Plan be used?

Everyone is encouraged to participate in improving the health of Maryland's residents. Achieving the objectives outlined in the HIP will require the combined efforts of organizations, families and individuals. The list below covers some of the opportunities for using the Maryland Health Improvement Plan:

- **Health-related organizations** are encouraged to use this document in developing organizational plans, developing priorities, and identifying opportunities for collaboration.
- **Faith communities, community-based organizations, and businesses** can use this document to guide health promotion activities, special events, and publications.
- **Schools and academic institutions** can use this document to assist in health promotion curricula and activities for students.
- **State and local government** representatives can use this document as a reference, and to identify areas for collaboration.
- **Local communities** can use this document to assist them in their health objective-setting processes.
- **Families and individuals** can use this document to set personal goals for health improvement.

What's next?

Project 2010 will continue to promote Maryland's public health. Major action areas, in non-priority order, include:

- Improving the statewide public health infrastructure;
- Garnering support of the Maryland business and faith communities;
- Narrowing the gap between public health theory and public health practice;
- Addressing gender, age, cultural, racial, and geographic health disparities;
- Updating Healthy Maryland and other related health status indicators;
- Improving health status measurement capability;
- Improving the quality of local level health data;
- Promoting collaboration among all health promotion advocates; and
- Broadening participation from all Maryland communities in Project 2010.

OVERVIEW OF MARYLAND'S POPULATION

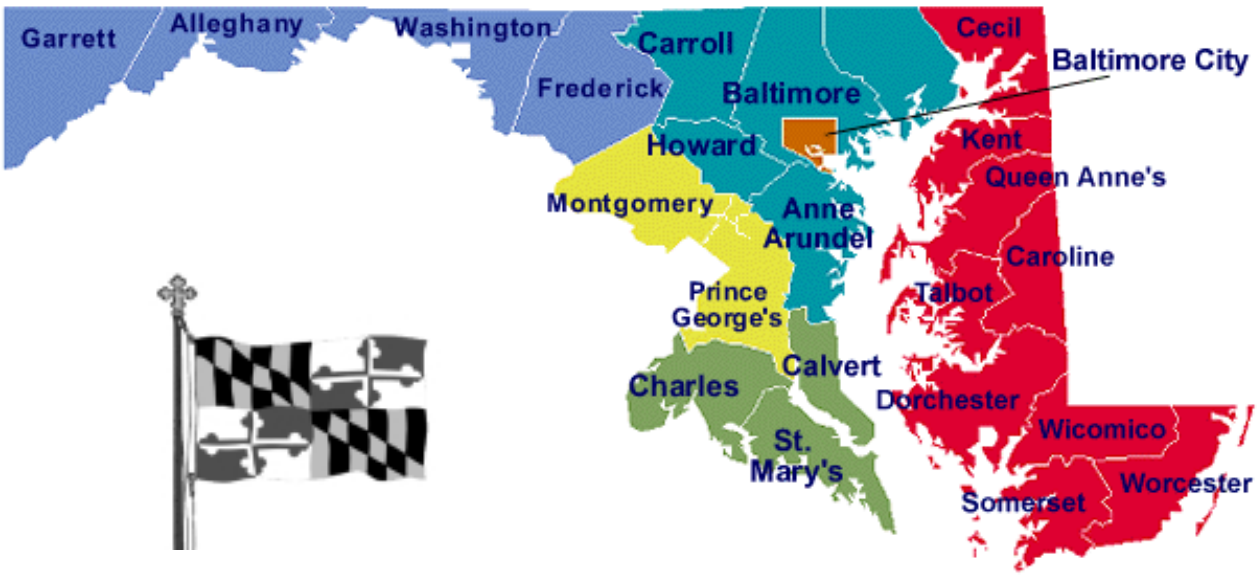
MARYLAND AT A GLANCE*

	Maryland	U.S.
Demographics[1,2]		
Total resident population (in 1,000), 1998	5,135	270,299
Under age 5 population (as % of total), 1998	6.7	7.0
Age 65+ population (as % of total), 1998	11.5	12.7
Non-white & Hispanic population (as % of total),1998	35.2	27.7
Health Status[3,4,5,6,7]		
Vaccine coverage for children 19-35 mos (% of), 1998	79	81
Smokers-- adult population (% of), 1998	22.4	22.9
AIDS cases reported per 100,000 pop., 1998	31.9	17.1
Infant Mortality (total), 1998	8.6	7.2
Low birth weight babies (% of)		
White Rate	6.4	6.5
African-American Rate	13.1	13.0
Health Care Coverage and Economic Status[8,9,10,11,12,13]		
Nonelderly insurance status (% of pop.) 1995-97 average		
Total private (% of)	76.9	70.7
Medicaid and other public (% of)	7.8	11.4
Total enrollment in HMOs (as % of pop./insured pop), 1998	34.9/40.5	29.2/34.7
Total uninsured (% of pop.) 1996-98 average	13.8	16.0
Uninsured by race (%), (White/Minority), 1995-97 average	9.6/21.2	11.8/26.2
Cost of employment-based family health coverage, 1998		
Total premium (average per employee)	$5,070	$4,953
Employee contribution (average per employee)	$1,647	$1,439
Personal income per capita, 1998	$30,023	$26,482
Median family income, 1998	$55,702	$42,471
Unemployment rate (% of civilian work force), 1998	4.6	4.5
Resources Available,[9,14]		
Primary Care Physicians** per 100,000 pop., 1997	103	84
Physician Specialists** per 100,000 pop., 1997	208	145
Registered Nurses per 100,000 pop., 1998	845	829
Population underserved by Primary Care MDs (% of), 1997	2.2	9.6
Utilization of Services[15]		
Average stay in community hospitals, 1997 (days)	5.5	6.1
Outpatient visits (incl. ER) to all hospitals (per 1,000 pop.), 1997	1063.7	1681.9
Emergency room visits to community hospitals (per 1,000 pop.) 1997	316.3	346.8

* Adapted from: "State Health Care Expenditures, Experience from 1998," Maryland Health Care Commission, January, 2000, Baltimore, MD.

** Count of nonfederal physicians (MDs or Osteopaths) in patient care: primary care is general or family practice, general internal medicine and general pediatrics; specialists are all other types of specialties, including OB/GYN.

Maryland is a diverse and varied State, both geographically and economically. Though small in size (only 9,843.62 sq. miles), with a 1999 population estimate of 5,171,634, the State ranked 19th in population, and 6th nationally in population density. Its geographic diversity is showcased by the Appalachian Mountains to the west and the Chesapeake Bay and Atlantic Ocean to the east. Frederick County has the largest land area (662.72 square miles), and Baltimore City has the smallest (80.34 square miles).



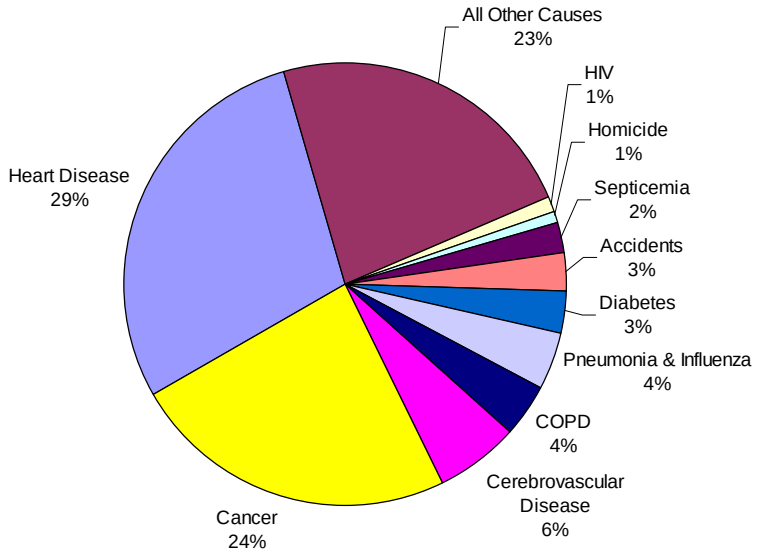
Maryland has much to be proud of, and, as any state, also has areas which need improvement. As a state, Maryland ranks first in the nation in the percentage of professional and technical workers in the workforce. Our State ranks first in the rate of high school completions (95%, compared to 86% for the nation), and second among the 50 states in the percentage of the population (31.8%) age 25 years and older who have completed a bachelor's degree or more. Maryland's median household income of $50,016 is the second highest in the nation, placing the State 29% above the national average. Maryland residents experience the lowest poverty rate in the nation, with 7.2% of the population living below the poverty level, compared to 12.7% for the United States as a whole. The Children's Rights Council, a national child advocacy organization, recently ranked Maryland as the seventh best state in the United States in which to raise a child. In the Mid Atlantic States, Maryland ranks first.

As impressive as this information is, certain segments of Maryland's population do not demonstrate the same progress as their national counterparts. The health status of some Marylanders has shown declining health, indicating an increased need for intervention. Areas which need increased attention include care for infants and children, heart disease, and influenza and pneumonia vaccinations. Both the percentage of births to women receiving late or no prenatal care and neonatal death rates were slightly higher in 1998 than in 1997.

Heart disease remains the leading cause of death, even though the age-adjusted mortality rate for heart disease has declined by 26% over the last 100 years. The combined death rate from pneumonia and influenza are still important, and actually rose from 1997 to 1998. Diabetes and HIV are also leading causes of death in Maryland.

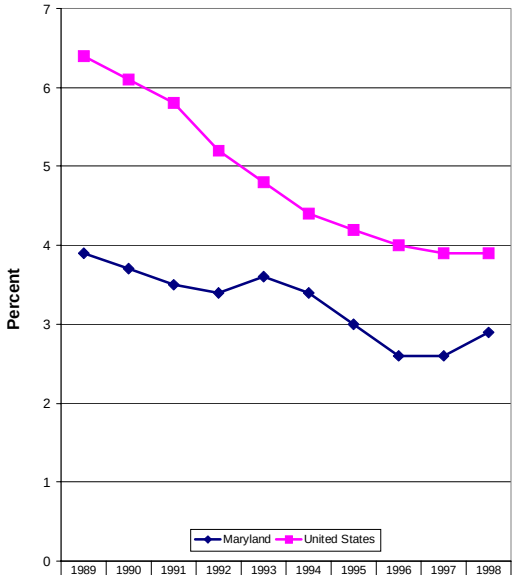
The following graphics provide a picture of Maryland's overall health status:

Percent Distribution of Deaths by Cause, Maryland, 1998



Source: Maryland Vital Statistics, 1998

Percentage of Women Receiving Late or No Prenatal Care, Maryland and the U.S., 1989-1998*

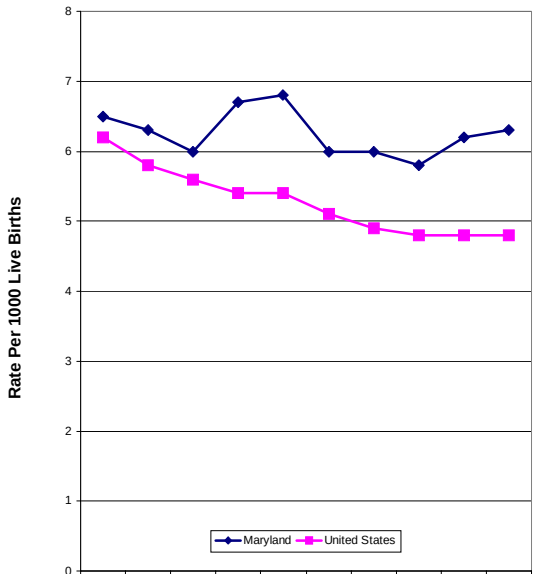


	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Maryland	3.9	3.7	3.5	3.4	3.6	3.4	3	2.6	2.6	2.9
United States	6.4	6.1	5.8	5.2	4.8	4.4	4.2	4	3.9	3.9

* Maryland figures exclude women for whom timing of prenatal care was unknown. Late care refers to prenatal care which begins during the third trimester of pregnancy.

Source: Maryland Vital Statistics, 1998

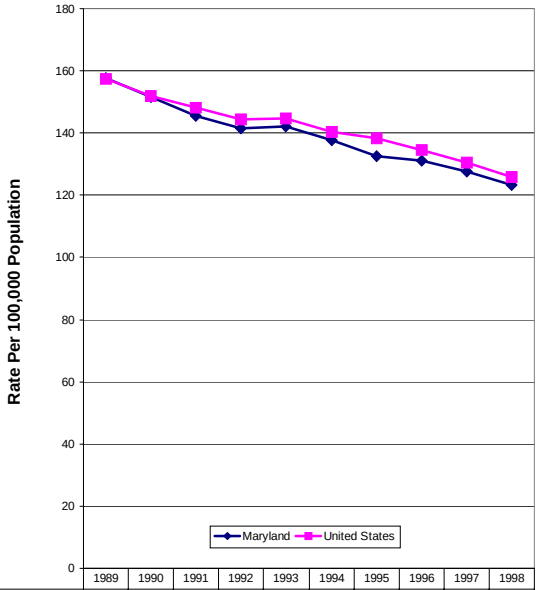
Neonatal Mortality Rate, Maryland and the United States, 1989-1998



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Maryland	6.5	6.3	6	6.7	6.8	6	6	5.8	6.2	6.3
United States	6.2	5.8	5.6	5.4	5.4	5.1	4.9	4.8	4.8	4.8

Source: Maryland Vital Statistics, 1998

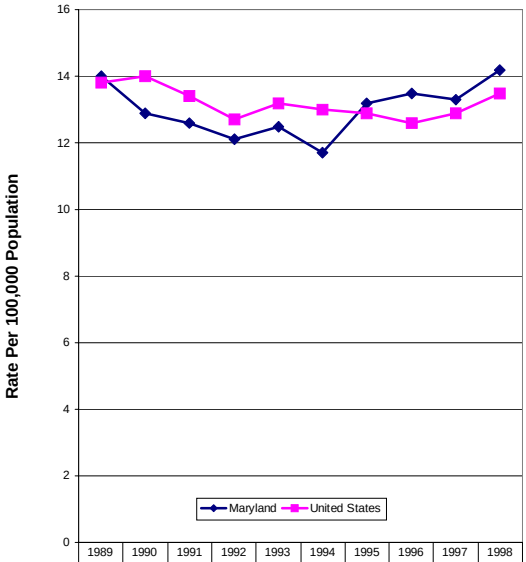
Age-Adjusted Death Rate for Diseases of the Heart, Maryland and the U.S., 1989-1998



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Maryland	157.7	151.6	145.6	141.5	142.1	137.7	132.6	131.1	127.5	123.4
United States	157.5	152	148.2	144.3	144.7	140.4	138.3	134.6	130.5	126

Source: Maryland Vital Statistics, 1998

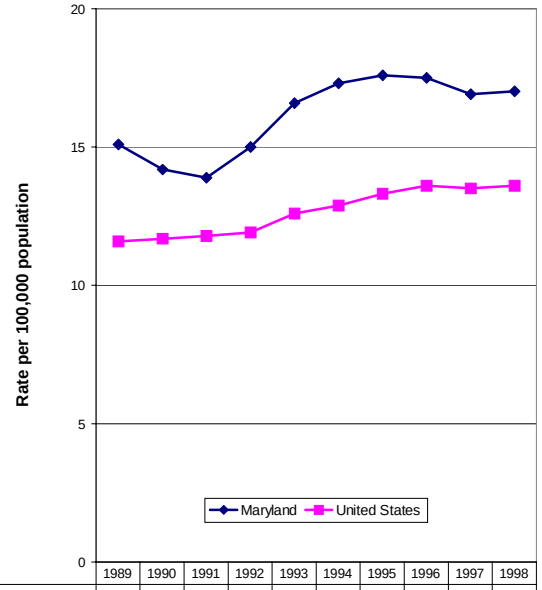
Age-Adjusted Death Rate for Pneumonia and Influenza, Maryland and the U.S., 1989-1998



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Maryland	14	12.9	12.6	12.1	12.5	11.7	13.2	13.5	13.3	14.2
United States	13.8	14	13.4	12.7	13.2	13	12.9	12.6	12.9	13.5

Source: Maryland Vital Statistics, 1998

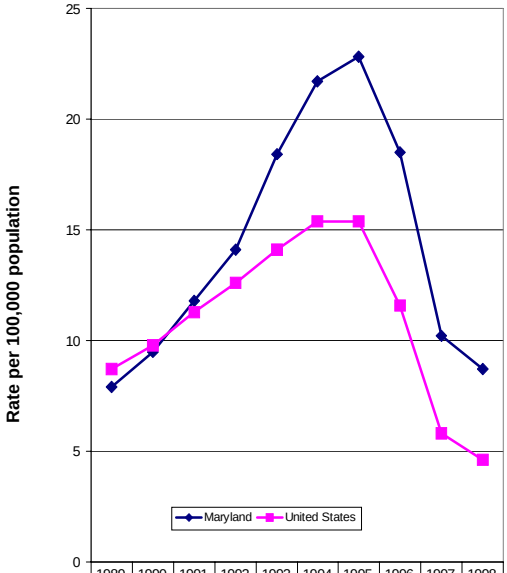
Age-Adjusted Death Rate for Diabetes, Maryland and the U.S., 1989-1998



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Maryland	15.1	14.2	13.9	15	16.6	17.3	17.6	17.5	16.9	17
United States	11.6	11.7	11.8	11.9	12.6	12.9	13.3	13.6	13.5	13.6

Source: Maryland Vital Statistics, 1998

Age-Adjusted Death Rate for Human Immunodeficiency Virus, Maryland and the U.S., 1989-1998



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Maryland	7.9	9.5	11.8	14.1	18.4	21.7	22.8	18.5	10.2	8.7
United States	8.7	9.8	11.3	12.6	14.1	15.4	15.4	11.6	5.8	4.6

Source: Maryland Vital Statistics, 1998

Data Sources

[1] From "Population Estimates for the U.S., Regions, and State by Selected Age Groups and Sex: Annual Time Series, July 1, 1990 to July 1, 1998 (includes revised April 1, 1990 census population counts)," U.S. Department of Commerce, U.S. Census Bureau, Population Division, Population Distribution Branch, *U.S. Census Bureau Web Site.* Website: http://www.census.gov/population/estimates/state/st-99-09.txt. Accurate as of July 15,1999. Regional estimates derived from: "1998 Population for Maryland Jurisdictions," September, 1999, Maryland Office of Planning. Website: http://www.op.state.md.us./MSDC.

[2] "Population Estimates for States by Race and Hispanic Origin: July 1, 1998." U.S. Department of Commerce, Census Bureau, Population Division, Population Distribution Branch. Website: http://www.census.gov/population/estimates/state/srh/srh98.txt. Accurate as of September 15, 1999.

[3] "Births and Deaths: Preliminary Data for 1998*."* By J. A. Martin, B. L. Smith, T. J. Mathews, and S. J. Ventura, 1999, *National Vital Statistics Reports*, *47* (25), Hyattsville, MD: National Center for Health Statistics. NOTE: Rates reported in Table are not age-adjusted.

[4] *Maryland Vital Statistics 1998 Preliminary Report,"* Maryland Department of Health and Mental Hygiene, Division of Health Statistics, 1998, Baltimore, MD, 1998. NOTE: Rates reported in Table 1 are not age-adjusted.

[5] "Table 2a. Estimated Vaccination Coverage with Individual Vaccines among Children 19-35 Months of Age by Census Division and State--United States," from the National Immunization Survey, 1998, Centers for Disease Control and Prevention, National Center for Health Statistics, National immunization Survey. Website: http://www.cdc.gov/nip/coverage.

[6] *1998 Behavioral Risk Factor Surveillance Summary Prevalence Report*, Centers for Disease Control and Prevention, June 18, 1999. Atlanta, GA: Centers for Disease Control and Prevention. NOTE: U.S. estimate includes Puerto Rico.

[7] "Table 2: rate reported for U.S. includes the 50 states and the District of Columbia, but excludes U.S. dependencies, possessions, and associated nations," Centers for Disease Control and Prevention, 1998, *HIV/AIDS Surveillance Report, 10* (2), 8. Regional estimates derived from: "AIDS Cases by Maryland County Diagnosed in 1998 and Reported through March, 1999," Maryland Department of Health and Mental Hygiene, AIDS Administration, 1999. Report. Baltimore, MD.

[8] "Current Population Reports, Series P620-208," by J.A. Campbell and the U.S. Bureau of the Census, 1999, *Health Insurance Coverage: 1998*. Washington, DC: U.S. Government Printing Office.

[9] *Reforming the Health Care System: State Profiles 1999*, by J. Lamphere, N. Brangan, S. Bee, and K. Griffin, 1999, Washington, DC: Public Policy Institute/American Association of Retired Persons.

[10] Maryland Health Care Commission (MHCC) calculations based on (1) population estimates from citation no. 1; (2) percent insured from citation 9; (3) national number enrolled in HMOs from *The InterStudy Competitive Edge, 9* (*2); Part II: HMO Industry Report;* Minneapolis, MN; and (4) Maryland residents enrolled in HMOs estimated by MHCC from Maryland Insurance Administration annual filings adjusted to include residents in HMO contracts located outside of Maryland.

[11] **National:** "Unemployment Rate -- Civilian Labor Force, Age 16 Years and Older, Seasonally Adjusted," U.S. Department of Labor, Bureau of Labor Statistics. Labor Force Statistics from the Current Population Survey. Web site: http://www.bls.gov/cpshome.htm. NOTE: Monthly statistics were averaged to produce yearly figure. **State:** "Maryland Civilian Labor Force, Employment and Unemployment by Place of Residence -- 1978-1998" Maryland Department of Labor, Licensing, and Regulation. Website: http://www.dllr.state.md.us/lmi/78.htm. **Counties:** "Regional Data --1990 to 1998 Annual Averages, Civilian Labor Force, Employment and Unemployment by Place of Residence," Maryland Department of Labor, Licensing, and Regulation. Website: http://www.dllr.state.md.us/lmi/9097avg.htm.

[12] **National and state:** "Regional Accounts Data, State Personal Income," U.S. Department of Commerce, Economic and Statistics Administration, Bureau of Economic Analysis. Website: http://www.bea.doc.gov/bea/regional/spi/. **Counties:** Maryland Office of Planning, Research and State Data Center, Bureau of Economic Analysis data.

[13] U.S. Agency for Health Care Policy and Research, Center for Cost and Financing Studies, 1996. MEPS IC-001: *1996 Employer-Sponsored Health Insurance Data.* **Total premium:** "Table 2U, 1996 Medical Expenditure Panel Survey, Insurance Component." Refers to the average family premium paid by private sector establishments that offer health insurance for family coverage per enrolled employee. Excludes temporary and contract workers. If more than one family rate was offered, the cost for a family of four was collected. **Employee contribution:** "Table 2V: 1996 Medical Expenditure Panel Survey, Insurance Component." Refers to the average contribution by an enrolled employee, excluding temporary or contract workers, for family coverage at private-sector establishments that offer health insurance. If more than one family rate was offered, the cost for a family of four was collected.

[14] Maryland Health Care Commission calculations based on: (1) American Medical Association Physician Masterfiles; (2) American Osteopathic Association data; and (3) Bureau of the Census State and County Population Estimates; all contained in U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions' *Area Resource File: February 1999 Release.*

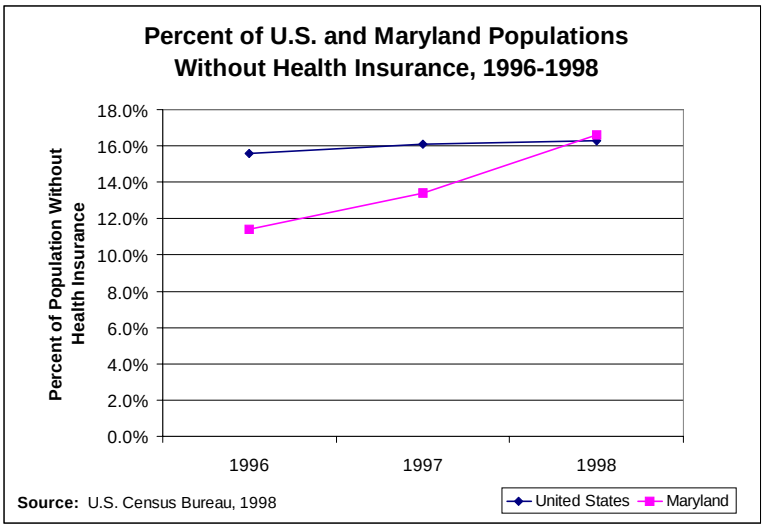
[15] *Health Care State Rankings,* (7th ed.), by K. Morgan, S. Morgan, N. Quitno (Eds.), 1999, Lawrence, KS: Morgan Quitno Press. NOTE: Primary care physicians, p.437; Physician specialists, p.445; Physician assistants, p.481; Occupancy rate in community hospitals, p. 212; Average stay in community hospitals, p.211; Admission to community hospitals, p. 208; Outpatient visits to community hospitals, p. 213; Emergency outpatient visits to community hospitals, p. 214; Surgical operations in community hospitals, p. 7. Population estimates derived from U.S. Department of Commerce, Census Bureau. "Total Resident Population on July 1, 1997." Website: http://www.census.gov/population/www/estimates/statepop.html. Accurate as of October, 1998.

HIGHLIGHTS, BY FOCUS AREAS, OF THE FULL HEALTH IMPROVEMENT PLAN

ACCESS TO HEALTH CARE

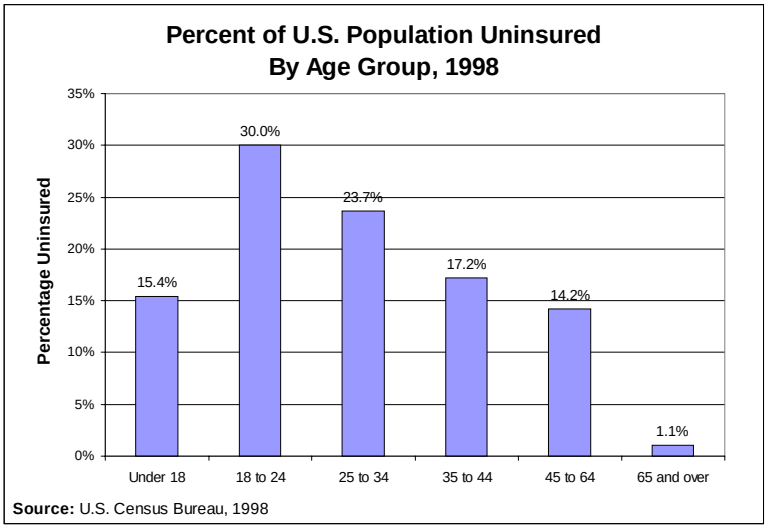
The Issue

Available evidence suggests that there are a variety of barriers to obtaining needed health care around the State. Accurate and timely monitoring of the dimensions of these problems is critical for development of appropriate solutions.



Access to health care, defined by the Institute of Medicine as "the timely use of personal health services to achieve the best possible health outcomes," is a national, state and local problem. It has been a focus of debate and discussion in many forums of both public and private sectors, and will most likely continue until access to health care improves. Lack of health insurance coverage may be the strongest indicator of inferior access to health care. In Maryland, three year averages of the Current Population Survey estimate that the number of uninsured has remained fairly constant, at approximately 700,000 residents, or nearly one in seven Marylanders (*Current Population Survey,* March 1999). In Maryland, minorities are twice as likely to be uninsured as white, non-Hispanic residents. Additionally, more than half of all adults in Maryland who are uninsured are between the ages of 18 and 34. Due to the increasing costs of health insurance, many of the uninsured include low-income, employed persons.

Most initiatives to improve access focus on providing health care to those who cannot afford health insurance. However, two other factors, the availability of services, and cultural and social barriers, also produce consequences which impact access to health care statewide and at the local level. Around the State, there exist many pockets of underserved populations who lack access to "willing providers," for needed primary, as well as various speciality care services.



Altogether, available information indicates that Maryland has a number of access issues. However, it is very difficult to demonstrate through the maze of available data, from both public and private sources, exactly what the most important access issues are and how the impact of these

issues vary in each local community. Accounting for the magnitude and distribution of these problems around the state should be the first step in crafting solutions to improve access on a statewide level.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Increase Access to Necessary Health Care Services*
Allegany County - *Promoting Access to Health Care for the Uninsured*
Anne Arundel County - *Access to Health Care for the Uninsured*
Baltimore County - *Increasing Access to Care by Eliminating Barriers in Baltimore County*
Carroll County - *Assuring Access to Quality Health Services*
Baltimore City - *Access to Health Care*

Priority focus in other jurisdictions

Access to Health Care is also identified as a priority area for FY2000 in:
Dorchester County • Frederick County • Harford County • Montgomery County
Prince George's County • Washington County • Wicomico County • Worcester County

Highlights of HIP strategies recommended to improve access to health care:
(*for in-depth details, see the complete text of each state and county module in the HIP)*

- Develop a method to accurately assess the health care needs of residents of Maryland at the state and local levels. (**State, Baltimore City, Anne Arundel and Carroll** counties)
- Assure access to health care/insurance coverage for residents (**Allegany County**), those with low income (**Anne Arundel County**), and children (**Baltimore County**).
- Develop a strategic plan to improve access to health care. (**State**)
- Establish a single point of contact for the uninsured in need of medical and pharmacological care. (**Allegany County**)
- Develop a network of health care providers who agree to provide services to eligible patients at reduced fees. (**Anne Arundel County**)
- Develop a method to ensure that county residents have reasonable transportation to and from medical appointments. (**Baltimore County**)
- Identify gaps in services and establish strategies to overcome barriers and unmet needs. (**Carroll County**)
- Expand support and outreach services. (**Baltimore City**)

Statewide Partners

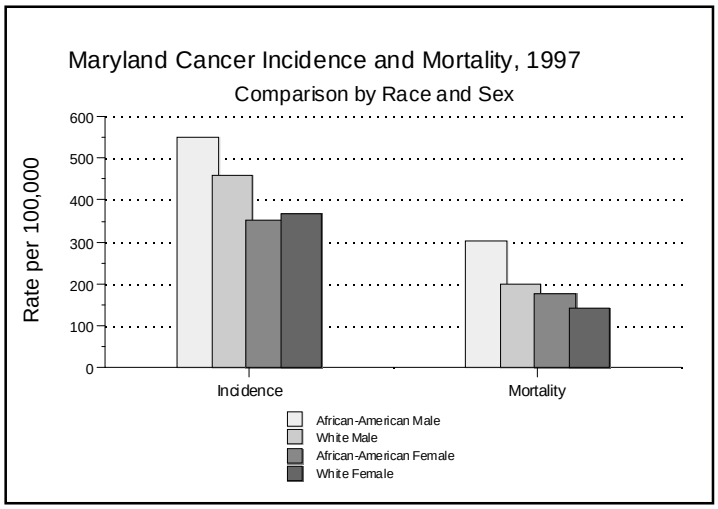
Maryland Community and Public Health Administration, DHMH • Maryland Department of Health and Mental Hygiene (DHMH) • Maryland Health Care Commission • Maryland Local Health Departments • Maryland Medical Care Program, DHMH • Office of Health Policy, DHMH • Office of Primary Care Services, DHMH • Office of Public Health Assessment, DHMH

CANCER

The Issue

Maryland's overall cancer rates exceed comparable national rates and have remained at these elevated levels for several years. Deployment of preventive measures, especially early detection, offers the greatest promise in addressing this problem.

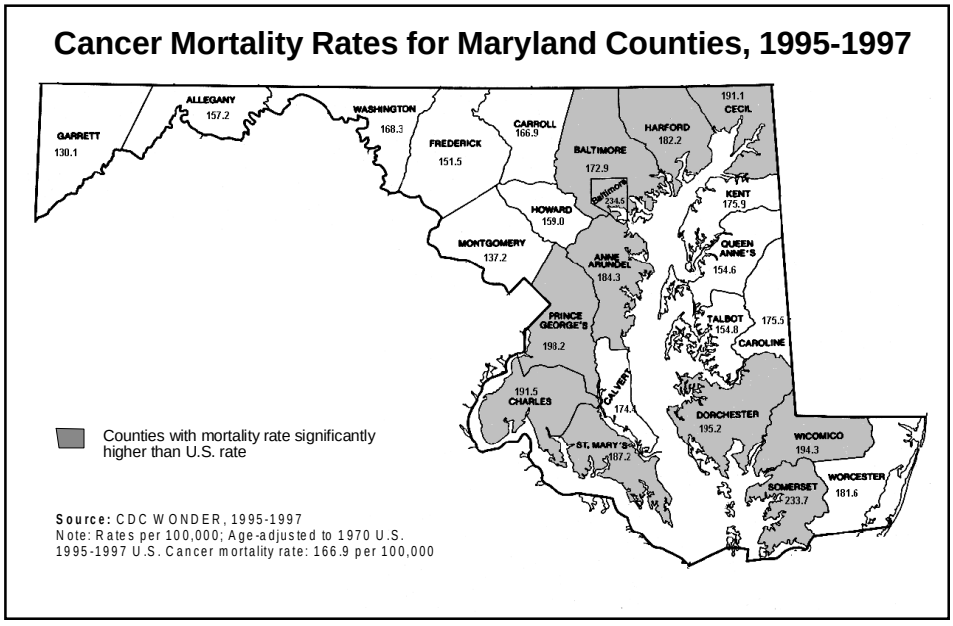
Overall rates of cancer mortality in Maryland have exceeded the comparable rates for the United States for several years, and have remained level for many years. The rates do not meet the Healthy People 2010 target. Cancer is the second leading cause of death in Maryland; one in every five deaths is due to cancer.



Source: Maryland Cancer Registry, 1997

In 1997, Maryland had the seventh highest death rate compared to other states in the nation. Additionally, 17 of the 24 Maryland jurisdictions had cancer mortality rates that were higher than the nation. Most cancer deaths in Maryland are due to lung, colon and rectum, breast, and prostate cancers. Other leading types of cancer in Maryland include bladder, melanoma of the skin, and oral cavity/pharynx. The incidence of cancer, as well as cancer mortality, is higher among African-American males than white males. Although white females have a higher incidence of cancer than African-American females, overall cancer mortality is higher among African-American females.

Implementing early detection programs for colorectal, breast, oral, skin and cervical cancer can significantly reduce mortality for these cancers. Controlling exposure to known risk factors, such as tobacco use, sun, and diet change can help prevent cancers of the lungs, skin, colon, and other cancers.



Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Conquering Cancer in Maryland*
Cecil County - *Lung Cancer* and *Female Breast Cancer*

Priority focus in other jurisdictions

Cancer is also identified as a priority area for FY2000 in:

Allegany County • Anne Arundel County • Carroll County • Charles County
Frederick County • Harford County • Montgomery County • Washington County
Wicomico County • Worcester County

Highlights of HIP strategies recommended to reduce cancer

(*for in-depth details, see the complete text of each state and county module in the HIP)*

- Reduce cancer deaths in Maryland. (Overall rates: **State;** Due to breast cancer among non-white women: **Cecil County**)
- Eliminate the disparity in cancer mortality rates between ethnic minorities and whites and between rural and urban geographic areas. (**State**)
- Decrease the number of current smokers. (**State**, **Cecil County**)
- Increase the number of women, ages 40 and older, who have an annual clinical breast exam and a mammogram. (**Cecil County**)

Statewide Partners

American Lung Association of Maryland • Cancer Advocacy Groups • Center for Cancer Surveillance and Control, DHMH • Centers for Disease Control and Prevention • Johns Hopkins University Medical Systems • Maryland Chapter of the American Cancer Society • Maryland community hospitals • Maryland Department of the Environment • Maryland Department of Health and Mental Hygiene (DHMH) • Maryland General Assembly • Maryland Local Health Departments • Med Chi–the Maryland State Medical Society • National Cancer Institute, National Institutes of Health • University of Maryland Medical Systems

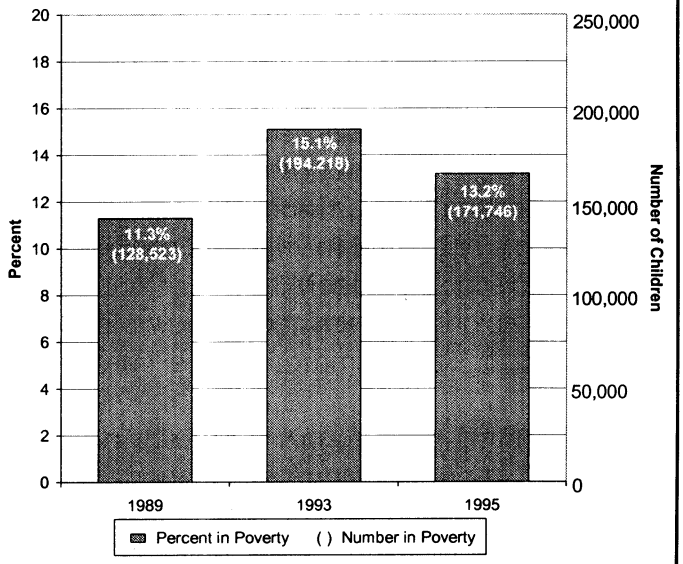
CHILD AND ADOLESCENT HEALTH

The Issue

Attention to the variety of challenges to the health of Maryland's children, its most important and precious resource, is critical in assuring a healthy future for them.

Maryland's 1.4 million children and adolescents are its most important and precious resource. There is every reason to expect that most of Maryland's children will grow up to be healthy and productive members of society. However, available data also suggest that there are troubling trends and challenges that could block the attainment of a healthy future for many of Maryland's children and adolescents. Most at risk are children who grow up in poor, minority and disadvantaged families and communities.

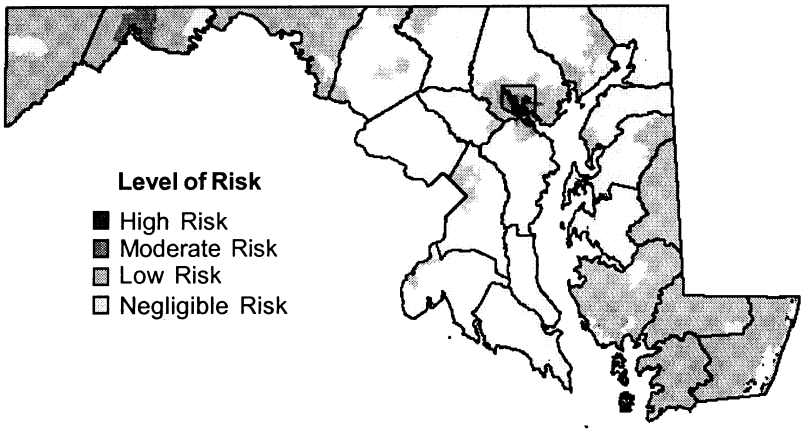
Percentage and Number of Children, Age 0-17, in Poverty in Maryland



Source: U.S. Census Bureau, March

In the *1999 Kids Count Data Book* published by the Annie E. Casey Foundation, Maryland, one of the nation's wealthiest states, ranked 24th on 10 indicators of child well-being. At least 12% of Maryland's children were defined to be living in families at high risk for future failure as measured by six indicators including poverty and lack of health insurance coverage. The consequences of child poverty are severe. Poor children are known to have higher death rates, increased chronic diseases such as asthma, and less access to health care services.

Predicted Areas of Risk for Lead Poisoning For Children Under 6 Years of Age Based on the Maryland Model (1999)



Source: 1990 U.S. Census Bureau Data and 1994-1996 MDE Lead Registry Data
Note: Census tract risks were converted to zip code risks using weighted proportional averages.

Two environmentally-linked health conditions, asthma and lead poisoning, are major causes of childhood morbidity. According to the American Academy of Pediatrics, obesity and obesity related illnesses, such as diabetes, are increasing among children and adolescents. In addition, numerous psycho-social and behavioral issues help determine the health of children and adolescents. These include mental and emotional disorders, crime, violence, risky behaviors such as substance use, and sexual activity. Attention to these challenges is important in improving the health of Maryland's children and adolescents. Additionally, children with special health care needs, for chronic physical, developmental, behavioral, or emotional conditions, may have other unique needs that must be addressed.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Preventing Asthma*, *Preventing Childhood Lead Poisoning*, *Promoting Good Nutrition and Physical Activity in Children*, *Improving Access to Health Care in Adolescents*, and *Improving the Service System for Children with Special Health Care Needs*
Calvert County - *Promoting Adolescent Health*
Caroline County - *Control of Sexually Transmitted Diseases (STDs) among the Adolescent Population of Caroline County*
Dorchester County - *Tobacco Cessation: Young Adults*
Frederick County - *Developing a Support System to Improve the Dental Health of Frederick County Children*
Garrett County - *Improving Dental Status of Children*
Kent County - *Reducing Sexually Transmitted Diseases in Teens*
Queen Anne's County - *Preventing Alcohol and Drug Use in the Population Less Than 21 Years Old*
Somerset County - *Reducing Tobacco Use among Youth*
Talbot County - *Reducing Interpersonal Violence in the Lives of Children*
Wicomico County - *Improve the Health and Well Being of Women, Infants, Children and Families*

Priority focus in other jurisdictions

Child Health is also identified as a priority area for FY2000 in:
Allegany County • Anne Arundel County • Baltimore County • Charles County
Harford County • Howard County • Montgomery County • Washington County
Worcester County • Baltimore City

Highlights of HIP strategies recommended to improve child health:
(*for in-depth details, see the complete text of each state and county module in the HIP)*

- Reduce asthma morbidity. (**State**)
- Improve outreach and screening for blood lead in children. (**State**)
- Reduce overweight and obesity among children and adolescents. (**State**)
- Increase health insurance coverage among adolescents. (**State**)

- Enhance and expand the health and related services network for children with special health care needs. (**State**)
- Promote healthy lifestyle choices for all boys and girls, including nutrition, physical activity, educational priorities, and psycho-social behavior. (**Calvert County**)
- Reduce the proportion of children who are regularly exposed to tobacco smoke at home. (**Dorchester County**)
- Develop a sustainable network of dental health providers accepting the Maryland Children's Health Program. (**Garrett County**)
- Conduct an after school program which focuses on prevention of underage drug and alcohol use. (**Queen Anne's County**)
- Support community groups in their efforts to prevent smoking among adolescents. (**Somerset County**)
- Reduce violence-related school suspensions. (**Talbot County**)
- Support funding for teen pregnancy prevention programs. (**Wicomico County**)

Statewide Partners

American Lung Association of Maryland • Center for Maternal and Child Health, DHMH • Johns Hopkins University • Maryland Association of County Health Officers • Maryland Chapter of American Academy of Pediatrics • Maryland Department of the Environment • Maryland Department of Health and Mental Hygiene (DHMH) • Maryland Department of Housing • Maryland Department of Human Resources • Maryland Hospital Association • Maryland Local Health Departments • Maryland Local Management Boards • Maryland Medical Assistance Program, DHMH • Maryland Office of Children, Youth,and Families • Maryland State Department of Education • University of Maryland Health Systems

CHRONIC DISEASES

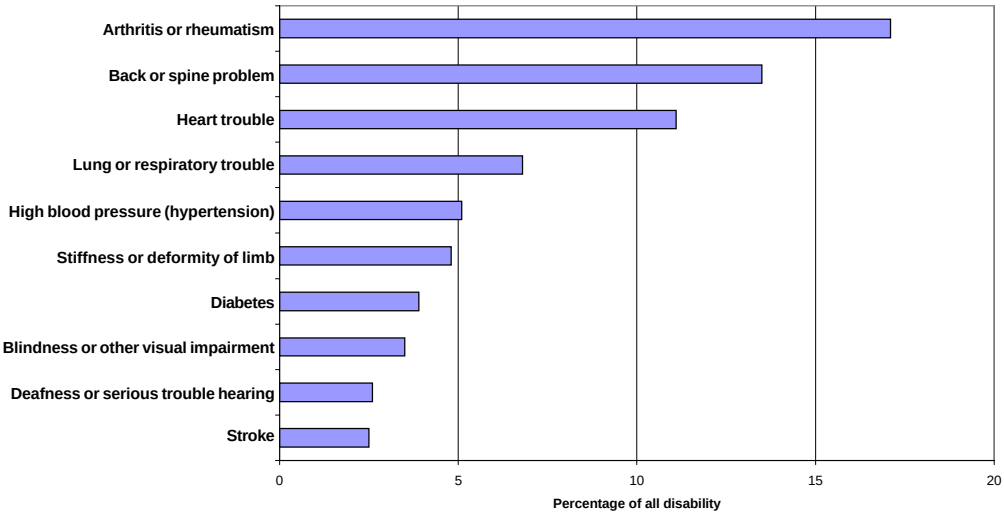
The Issue

The list of threats from chronic diseases -- long-term illness, disability, and decreased quality of life -- that affects Marylanders is long and ever-increasing. Diabetes, smoking-related illnesses, asthma, obesity, cardiovascular disease, and arthritis lead the list and contribute to a large financial burden for individuals, their families, and society.

Chronic diseases are among the most prevalent, costly, and preventable of all health problems. Seven out of every 10 Americans who die each year, more than 1.7 million people, die from a chronic disease. While older Americans are particularly at risk, chronic diseases also attack men and women in the prime of their lives. Additionally, most premature deaths among minority groups and the disadvantaged are due to chronic diseases. These conditions account for the largest part of the health gap between African-American and white Americans. Virtually every American family is adversely affected by some form of chronic disease, through long term illness, disability, decreased quality of life, and the large financial burden brought on by these diseases.

Chronic diseases rarely resolve without intervention. They usually are not cured by medication or treatment, and require lifelong monitoring and maintenance. However, damaging behaviors, directly and indirectly linked to many chronic diseases, can be changed. Prevention measures, the outcomes of both behavioral and clinical research, can be effectively applied to benefit individuals and their families.

Leading Causes of Disability Among Persons Aged 15 Years and Older, United States, 1991-1992,



Source: Centers for Disease Control and Prevention. (1994). "Prevalence of disability and associated health conditions–United States, 1991-1992." *Morbidity and Mortality Weekly Report, 43* (40), 730-731,737. Atlanta, GA.

The list of chronic diseases that affect Americans and Marylanders is long and ever-increasing. Diabetes, smoking related illnesses, asthma, obesity, cardiovascular diseases, and arthritis all contribute to increased individual and societal burden.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Arthritis*
Howard County - *Preventing Diabetes and its Complications*

Priority focus in other jurisdictions

Chronic disease is also identified as a priority area for FY2000 in:
Allegany County • Calvert County • Carroll County • Cecil County • Charles County
Dorchester County • Frederick County • Harford County • Montgomery County
Washington County • Wicomico County • Worcester County

Highlights of HIP strategies recommended to decrease chronic disease
(*for in-depth details, see the complete text of each state and county module in the HIP)*

- Develop a state arthritis action plan to promote public awareness of the disease, early diagnosis and appropriate self management, and development of medical continuing education programs for health care providers. (**State**)
- Build capacity within the Department of Health and Mental Hygiene to deal with the awareness of arthritis and related conditions. (**State**)
- Develop tools to allow effective assessment and monitoring of provider care and patient compliance of diabetes. (**Howard County**)
- Initiate a public campaign to educate the adult population about the seriousness, costs, and risk factors associated with diabetes. (**Howard County**)

Statewide Partners

Arthritis Foundation of Maryland • Delmarva Foundation for Medical Care • Delmarva Orthopaedic Clinic • Governor's Council on Physical Fitness • Johns Hopkins University School of Medicine • Lupus Foundation of Maryland • Maryland Department on Aging • Maryland Health Care Commission • Maryland Medical Assistance Administration, DHMH • Maryland Society for Rheumatic Diseases • Maryland State Advisory Council on Arthritis • Maryland State Osteoporosis Task Force • Med Chi–the Maryland State Medical Society • Office of Health Promotion, Education, and Tobacco Use Prevention, DHMH • University of Maryland, Baltimore County

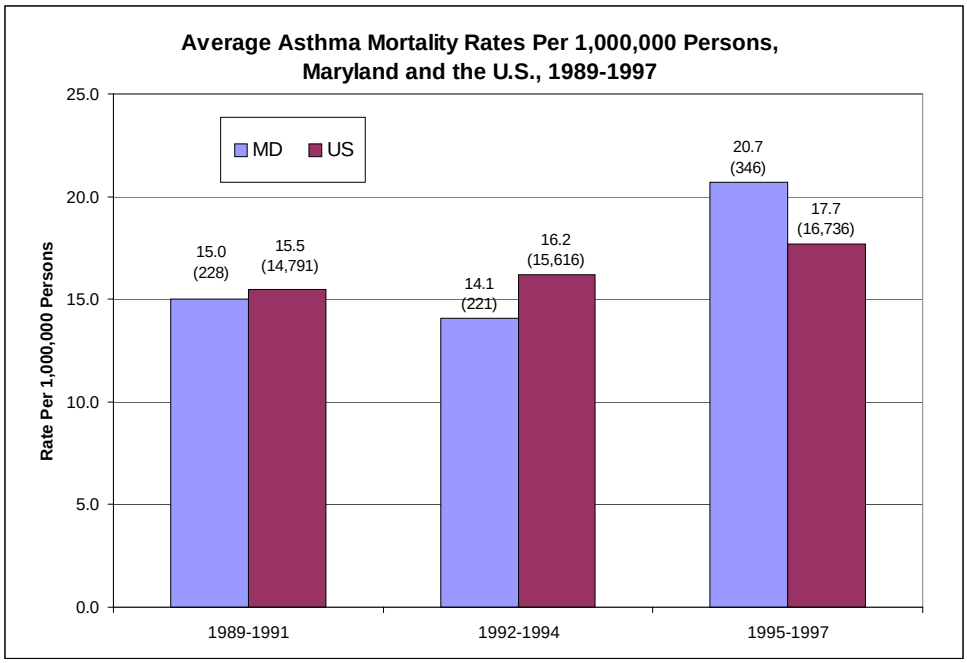
ENVIRONMENTAL HEALTH

The Issue

Exposures to hazardous agents, natural or manmade, in the air, water, soil, and food are major contributors to illness, disability, and death worldwide. Among these, asthma, a health problem linked to indoor and outdoor air pollution, is a growing health problem in the U.S. and in Maryland.

Exposures to hazardous agents in the air, water, soil and food, and to other physical hazards in the environment are major contributors to illness, disability and death worldwide. Poor environmental quality is estimated to be directly responsible for approximately 25% of all preventable ill health in the world, with diarrheal diseases and respiratory infections leading the list. Poor environmental quality has its greatest impact on the people whose health status may already be at risk, especially due to age and illness.

"Environmental justice" was defined in 1999 by the Maryland Advisory Council on Environmental Justice as equal protection from environmental hazards for all people regardless of race, income, culture and social class. The Environmental Protection Agency has recommended a list of 45 variables to be used in assessing environmental justice concerns. Outdoor air quality, water quality, toxins and waste, healthy homes and healthy communities, and the infrastructure to support them are all vital to environmental concerns that face Maryland. Asthma, a health problem exacerbated by indoor and outdoor air pollution, is increasing in the U.S. and in Maryland. Asthma is presented as an example of a public health concern with many of the components of a potential environmental justice problem.



Note: Age-Ajusted to the 1970 U.S. Population.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Environmental Justice - Asthma Mortality*
Howard County - *Reducing the Effects of Asthma*

Priority focus in other jurisdictions

Environmental health is also identified as a priority area for FY2000 in:
Anne Arundel County • Harford County • Baltimore City

Highlights of HIP strategies recommended to improve environmental health
(for in-depth details, see the complete text of each state and county module)

- Develop public health data that are useful for addressing environmental justice concerns. Asthma mortality and its relationship to geography, race, and socio-economic status will be used as a demonstration. (**State**)
- Demonstrate the use of geographic information systems (GIS) technology as a tool for the production of public health data that are useful for addressing environmental justice concerns. (**State**)
- Monitor provider care using the National Asthma Education and Prevention Program Guidelines for Diagnosis and Management of Asthma. (**Howard County**)
- Conduct educational campaigns on environmental factors affecting the quality of life of persons with asthma. (**Howard County**)

Statewide Partners

Baltimore Urban League Environmental Project • Community and Public Health Administration, DHMH • Environmental Health Risk Assessment Program • Maryland Department of the Environment (MDE) • Maryland Department of Health and Mental Hygiene (DHMH) • Maryland Local Health Departments • Office of Environmental Health Coordination, DHMH • Technical and Regulatory Services Administration, MDE

FAMILY PLANNING

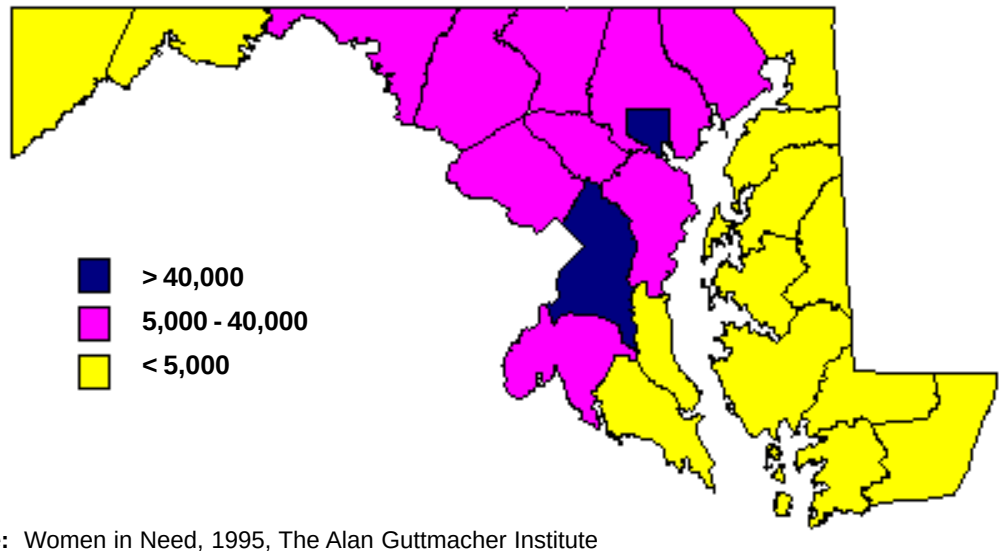
The Issue

Unintended pregnancies, which are likely to have a variety of adverse health and socioeconomic consequences, are the chief indicators of a breakdown in family planning. In Maryland, there is evidence of gaps in service and coverage for these critically needed reproductive health resources.

Family planning is the process of establishing the preferred number and spacing of one's children, selecting the means to achieve these goals, and effectively using that means. Intended pregnancy is a pregnancy that a woman states was wanted at the time of conception.

It is estimated that 49% of pregnancies in the U.S. are unintended. Pregnancies that are not intended run a higher risk of adverse consequences for women including pregnancy termination, reduced educational achievement and employment opportunity, and increased welfare dependency. Unintended pregnancy contributes to health care costs regardless of the outcome. Medically, unintended pregnancies have an increased likelihood of infant and maternal morbidity and mortality. Infants born to teenage mothers, especially mothers under 15 years of age who have the highest likelihood of unintended pregnancy, are more likely to suffer from low birth weight, neonatal mortality, and sudden infant death syndrome. They also may be at greater risk of child abuse, neglect, and behavioral and educational problems at later stages of life.

Number of Women in Need of Publicly-Supported Family Planning Services, Maryland, 1995



Source: Women in Need, 1995, The Alan Guttmacher Institute
Note: Total 257,430

In Maryland, there is evidence that the number of unintended pregnancies has declined over the last decade. From 1993 to 1997, there has been a decrease in the birth rates throughout the State and in Baltimore City. However, there still remain gaps in service and coverage for family planning. Also, among people covered by private insurance, family planning and contraceptive services are frequently not included as a benefit or may require deductibles or copayments.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Promoting Pregnancy Intendedness and Family Planning in Maryland*
Calvert County - *Promoting Adolescent Health*

Priority focus in other jurisdictions

Family Planning is also identified as a priority area for FY2000 in:
Allegany County • Dorchester County

Highlights of HIP strategies recommended to promote family planning
(for in-depth details, see the complete text of each state and county module)

- Increase the proportion of intended pregnancies in Maryland. (**State**)
- Increase the proportion of Maryland females at risk of unintended pregnancy (and their partners) who use contraception. (**State**)
- Reduce the percentage of births to adolescents under 18 years of age. (**Calvert County**)
- Promote healthy lifestyle choices for boys and girls for nutrition, physical activity, and educational priorities, in addition to psycho-social behaviors. (**Calvert County**)

Statewide Partners

Baltimore Community Foundation • Center for Maternal and Child Health, DHMH • Johns Hopkins University, School of Hygiene and Public Health • Maryland Community Health Centers • Maryland Local Health Departments • Maryland Primary Care Services, DHMH • Pfizer, Inc. • Planned Parenthood of Maryland, Inc.

HEART DISEASE AND STROKE

The Issue

In Maryland, heart disease and stroke are leading causes of death and disability for both men and women. Their impact is felt daily on thousands of Marylanders and their families.

Heart disease is the leading cause of death for all Americans. Cardiovascular disease (which encompasses both heart disease and stroke) kills and disables people from all walks of life. National costs associated with medical care, lost productivity, and lost future wages due to cardiovascular disease were projected to be $286 billion in 1999. Its long- and short-term impact is felt daily on thousands of Marylanders.

In Maryland, heart disease and stroke are leading causes of death and disability for both men and women. High blood cholesterol, high blood pressure, cigarette smoking, physical inactivity, and obesity are risk factors for cardiovascular disease. Available data show elevated levels of these factors, especially overweight and obesity, among the population. Behavioral changes, beginning in childhood, to achieve healthy diet and to increase physical activity can help to decrease overweight, high blood pressure and high blood cholesterol, and, subsequently, rates of heart disease and stroke.

Percent of Adult Population Reporting Factors Related to Heart Disease and Stroke In Maryland, 1990-1998

Risk Factor	1990 Percent	1997/98 Percent
High blood pressure	20.6	23.8
High blood cholesterol	25.9	28.6
Obesity	12.0	20.5
Overweight	31.1	35.0
Fruit/Vegetable intake	N/A	69.9
Physically inactive	30.0	20.3
Irregular activity	30.8	30.1
Regular activity	30.1	33.2
Regular, sustained activity	7.8	16.4

Source: Maryland Behavioral Risk Factor Surveillance System, 1990-1998

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Preventing Heart Disease and Stroke*
Cecil County - *Heart Disease and Stroke*

Priority focus in other jurisdictions

Heart disease and stroke are also identified as a priority area for FY2000 in:
Carroll County • Charles County • Dorchester County • Harford County
Washington County • Wicomico County

Highlights of HIP strategies recommended to decrease heart disease and stroke

(for in-depth details, see the complete text of each state and county module)

- Reduce cardiovascular disease deaths. (**State**)
- Reduce stroke deaths. (**State** and **Cecil County**)
- Increase the proportion of adults, youth, and children who engage in regular physical activity. (**State**)
- Increase the proportion of adults who have their blood pressure and blood cholesterol level checked regularly. (**Cecil County**)

Statewide Partners

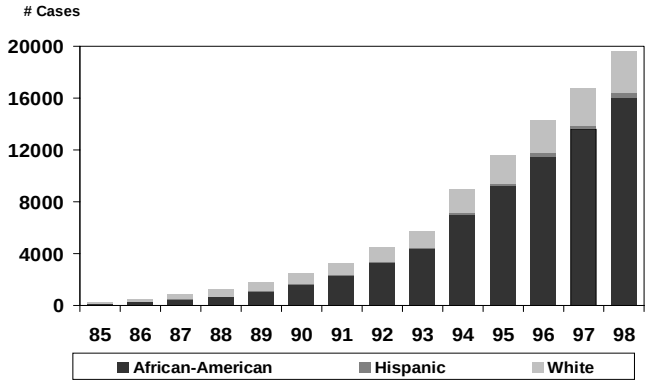
American Heart Association (Maryland Affiliate) • Baltimore Alliance for the Prevention and Control of Hypertension and Diabetes • Delmarva Foundation for Medical Care • Maryland Health Care Commission • Johns Hopkins University • Maryland Association of County Health Officers • Maryland Chapter of the American Cancer Society • Maryland Department of Health and Mental Hygiene (DHMH) • Maryland Hospital Association • Maryland Nurses Association • Maryland Office on Aging • Maryland State Advisory Council on High Blood Pressure and Related Risk Factors • Maryland State Advisory Council on Physical Fitness • Maryland State Department of Education • Med Chi–the Maryland State Medical Society • Morgan State University • Network to Improve Community Health • Office of Chronic Disease Prevention, DHMH • University of Maryland, Baltimore County • Veterans Administration Medical Center • Women's Health Promotion Council

HIV

The Issue

Maryland had the fourth highest incidence of AIDS nationally in 1999. HIV/AIDS is a significant cause of illness, disability, and death that disproportionately affects males and African-Americans in Maryland.

Number of Living HIV and AIDS Cases in Maryland During Each Year by Race/Ethnicity, 1985-1998

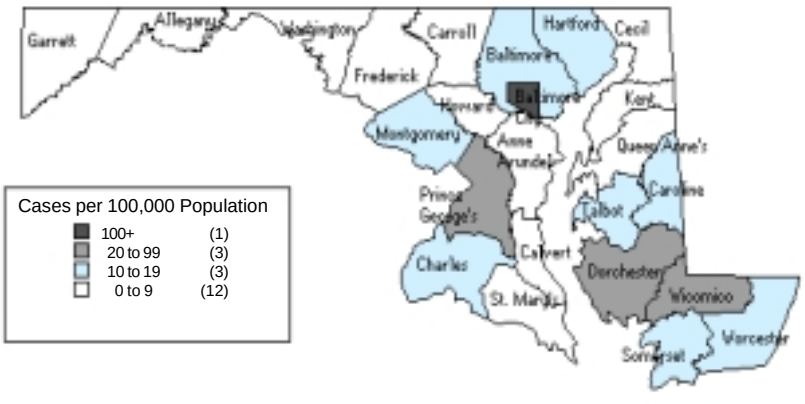


Source: AIDS Administration, DHMH, March 2000
Note: HIV surveillance began in year 1994.

Human Immunodeficiency Virus (HIV) is the pathogenic organism responsible for Acquired Immunodeficiency Syndrome (AIDS). HIV cases are first time reports of HIV infection in pre-AIDS individuals with a positive HIV test and Maryland residence at the time of diagnosis. AIDS emerged in the early 1980s as a new infectious disease. The causative agent of HIV/AIDS was discovered several years later. HIV/AIDS has been reported in almost every racial and ethnic population, every age group, and every socio-economic group in every state in the United States, and in many other countries. In this country, HIV/AIDS is a significant cause of illness, disability, and death, despite declines in HIV-disease and AIDS during 1996 and 1997.

Maryland had the fourth highest AIDS incidence rate in the United States from July 1998 to June 1999. Since reporting began in 1994, a cumulative total of 12,111 non-AIDS HIV infections has

Average Annual HIV Incidence in Maryland, 1996-1998



Source: AIDS Administration, DHMH, March 2000

been reported in Maryland as of September 1999. Baltimore City, suburban Baltimore, and suburban Washington account for over 75% of Maryland's cumulative HIV cases. HIV disproportionately affects males and African-Americans in Maryland. The African-American population has the highest rates of HIV among both genders, followed by the Hispanic and white populations.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Reducing HIV Infection in Maryland*, and *Extending Life for People with HIV*.

At the local level, while no jurisdictions have chosen HIV for their module, two jurisdictions have chosen related topics:

Caroline County - *Control of Sexually Transmitted Diseases (STDs) Among the Adolescent Population of Caroline County*

Kent County - *Reducing Sexually Transmitted Diseases (STDs) in Teens*

Priority focus in other jurisdictions

HIV and/or related topics are included as priority areas for FY2000 in:

Charles County • Harford County • Montgomery County • Washington County

Highlights of HIP strategies recommended to decrease HIV and STDs

(for in-depth details, see the complete text of each state and county module)

- Eliminate the increase in HIV incidence particularly among African-American and other disproportionately affected groups. (**State**)
- Expand the availability of and access to HIV counseling and testing services for disproportionately affected groups. (**State**)
- Increase provider skills to deliver quality HIV risk reduction interventions. (**State**)
- Decrease the rate of new AIDS cases. (**State**)
- Provide training to all teachers and guidance counselors who deal with this topic. (**Caroline County**)
- Host a community forum to educate parents and the general public about the problem. (**Kent County**)

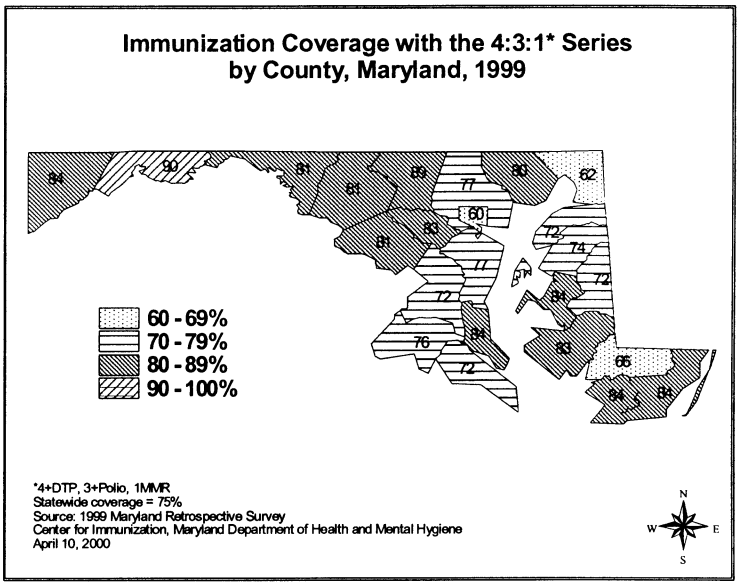
Statewide Partners

AIDS Administration, DHMH • Epidemiology and Disease Control Program, DHMH • HIV Prevention Community Planning Group • Johns Hopkins Medical Institution/University • Maryland Association of County Health Officers • Maryland HIV Care Consortia • Maryland Local Health Departments • Maryland Medical Assistance Program, DHMH • Maryland Mental Hygiene Administration, DHMH • Maryland State Department of Education • Med Chi–the Maryland State Medical Society • Morgan State University • University of Maryland, Baltimore County • University of Maryland Medical Systems

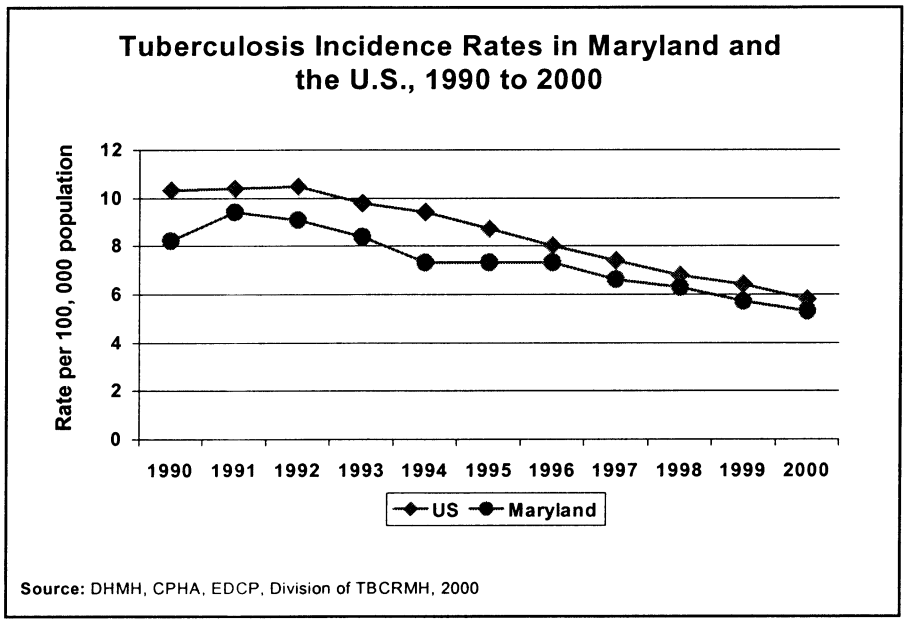
IMMUNIZATION AND INFECTIOUS DISEASES

The Issue

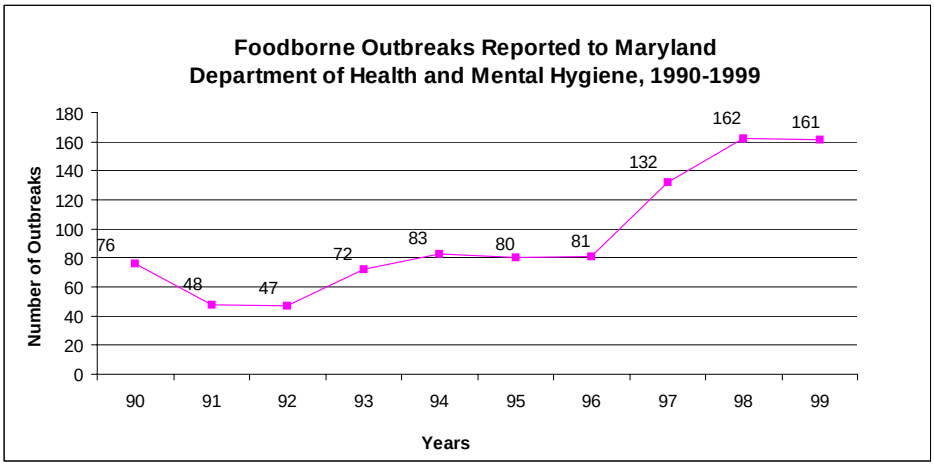
Immunization rates in Maryland are not yet at levels which approach the national Healthy People targets to be achieved by 2010. Administration of appropriate vaccines to children and adults can help to control a variety of preventable infectious diseases.



Low immunization rates and diseases that can be prevented by vaccines continue to be concerns in Maryland, especially among preschoolers and the elderly. Vaccines can prevent the debilitating, and sometimes fatal effects of many (such as polio, measles, and rubella), but not all, infectious diseases. Although significant progress has been made since 1996, immunization rates in Maryland are not yet at levels which approach the national 2010 target rates. The immunization coverage rates for the standard childhood series of immunizations (80% in Maryland) mirrors the national rate, for children 19 to 35 months. In addition to the very young, many adults are at increased risk for vaccine-preventable diseases (including influenza and pneumonia). Maryland's coverage rates need to increase in order for more vaccine-preventable diseases to be prevented.



Healthcare facility-acquired, or noscomial, infections (including Legionnaire's disease); zoonotic diseases (including Lyme Disease and West Nile virus), which develop when there is contact between humans and disease carrying animals; foodborne illnesses; and tuberculosis occur at varying rates throughout Maryland. Altogether, preventable infectious diseases in Maryland result in increased morbidity, mortality, and associated healthcare costs in addition to other costs that total millions of dollars each year.



Source: Maryland Outbreak Database. Division of Outbreak Investigation, EDCP, DHMH.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Vaccine Preventable Diseases, Prevention of Infections Acquired within Healthcare Facilities, Preventing Diseases Spread by Animals and Insects, Reducing and Controlling Foodborne Illness*, and *Preventing Tuberculosis*

Washington County - *Reduction of Mortality Associated with Influenza and Pneumonia*

Priority focus in other jurisdictions

Infectious Diseases is also identified as a priority area for FY2000 in:

Anne Arundel County • Prince George's County • Worcester County

Highlights of HIP strategies recommended to decrease infectious diseases:

(*for in-depth details, see the complete text of each state and county module in the HIP)*

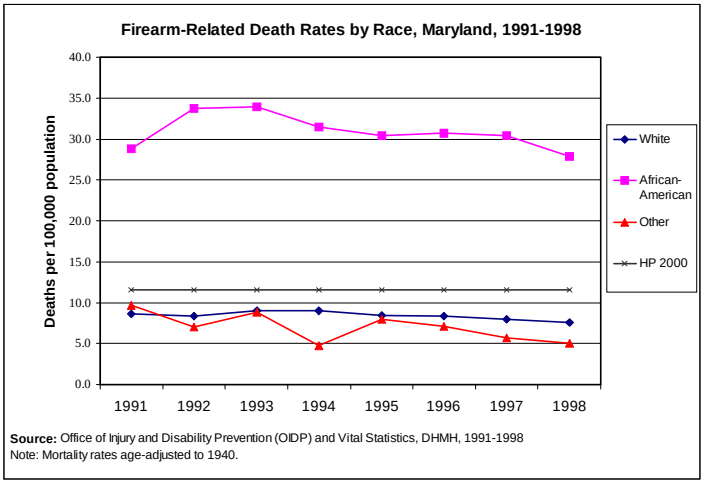
- Increase immunization coverage (diphtheria, tetanus, pertussis, polio, measles, mumps, and rubella) among children. (**State**)
- Increase influenza and pneumococcal immunization coverage among adults. (**State** and **Washington County**)
- Reduce cases of Lyme Disease and tuberculosis. (**State**)
- Reduce the number of foodborne outbreaks. (**State**)

Statewide Partners

AIDS Administration, DHMH • American Lung Association (Maryland affiliate) • The Annie E. Casey Foundation • Association for Professionals in Infection Control and Epidemiology, Inc.: Greater Baltimore Chapter, Delmarva Chapter, and Metro Washington, D.C. Chapter • Baltimore Medical Systems, Inc. • Centers for Disease Control and Prevention • Choptank Community Health System, Inc. • Eastern Shore Area Health Education Center • Epidemiology and Disease Control Program, DHMH • Greater Baden Medical Services, Inc. • Howard Community College • Johns Hopkins University • Maryland Chapter of American Academy of Pediatrics • Maryland Chapter of American Academy of Family Practitioners • Maryland Department of Agriculture • Maryland Department of Health and Mental Hygiene (DHMH), Infection Control Professionals • Maryland Department of Natural Resources • Maryland Department of Public Safety and Correctional Services • Maryland Governor's Commission on Migratory and Seasonal Farm Labor • Maryland Hospital Association • Maryland Immunization Partnership • Maryland Local Health Departments • Maryland Office of New Americans (MONA) • Maryland Partnership for Prevention • Maryland State Board of Education • Maryland State Department of Education • Maryland Thoracic Society • Maryland Tuberculosis Elimination Committee • MedChi–the Maryland State Medical Society • Metropolitan Council of Governments (COG) • National Jewish Medical and Research Center for Respiratory Disease • New Jersey Medical School, National Tuberculosis Center • Restaurant Association of Maryland • Scientific Work Group to Study Legionella Bacteria in Water Systems • Telemon Corporation • Three Lower Counties Community Services • University of Maryland, Baltimore

INJURY AND VIOLENCE PREVENTION

The Issue

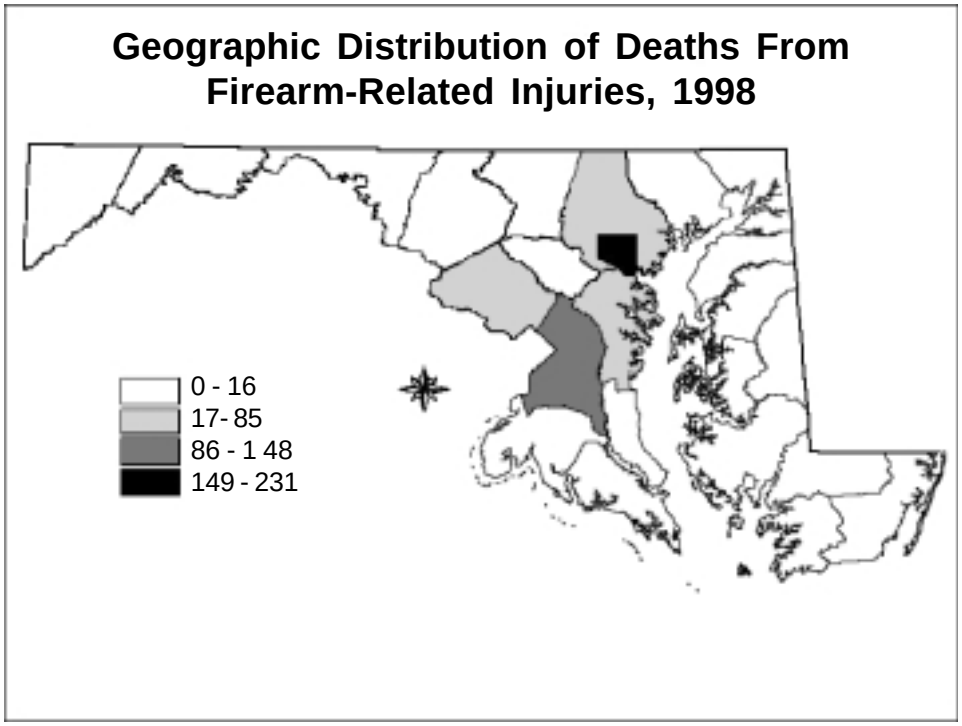


Source: Office of Injury and Disability Prevention (OIDP) and Vital Statistics, DHMH, 1991-1998
Note: Mortality rates age-adjusted to 1940.

Firearm-related deaths, a leading cause of injury deaths in Maryland, occur at rates that have surpassed comparable national rates. A variety of preventive measures, if implemented, can help change this trend.

Violence and injury claim the lives of many of the nation's young people and threatens the health and well being of people of all ages in the United States. On an average day in America, 53 people die from homicide and a minimum of 18,000 people survive interpersonal assaults, 84 people complete suicide, and as many as 3,000 people attempt suicide. Youth are involved as both perpetrators and victims of violence. The elderly, females, and children are targets of both physical and sexual assaults, often initiated by an acquaintance.

Injury is often thought of as an unpreventable "accident." But, in fact, many injuries are not accidents, nor are they random uncontrollable acts of fate. Most injuries, due to a variety of causes such as motor vehicle crashes, firearms, poisonings, suffocation, falls, fires, and drownings, are predictable and preventable. Suicide and homicide are the leading causes of intentional injury deaths.



Source: DHMH Office of Health Statistics, 1998

Firearm-related deaths are the leading cause of injury deaths occurring in Maryland. Fortunately, from 1989 to 1998, the firearm-related death rate declined overall to 14.1 per 100,000 in 1998, from 17.2 per 100,000 in 1993.

Maryland's firearm-related death rate has surpassed that of the United States every year since 1992 and has fallen short of the Healthy People 2000 goal of 11.6 per 100,000 deaths every year since 1990.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Reducing Firearm-Related Deaths*
Talbot County - *Reducing Interpersonal Violence in the Lives of Children*

Priority focus in other jurisdictions

Injury and Violence Prevention is included as a priority area for FY2000 in:
Anne Arundel County • Calvert County • Carroll County • Charles County
Dorchester County • Harford County • Montgomery County • Washington County

Highlights of HIP strategies recommended to decrease injury and violence
(for in-depth details, see the complete text of each state and county module)

- Decrease the gap between African-American and white firearm-related deaths. (**State**)
- Reduce the juvenile violent crime arrest rate. (**Talbot County**)

Statewide Partners

Johns Hopkins University • Maryland Association of County Health Officers • Maryland Local Health Departments • Maryland Local Management Boards • Office of Injury Prevention, DHMH • University of Maryland, Baltimore County • Violence Policy Center • Violence Research Group

MATERNAL AND INFANT HEALTH

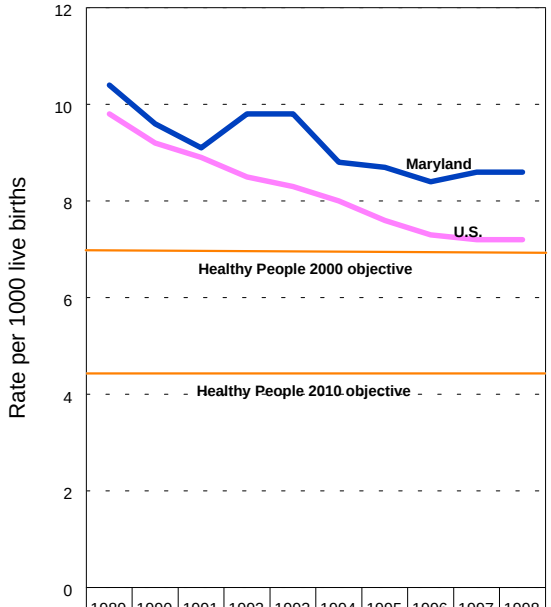
The Issue

The infant mortality rate (IMR) is a principal indicator of the health of mothers and their infants in our society. During the past decade, the IMR in Maryland has been consistently higher than that of the nation and the Healthy People goals.

The health of mothers and their infants is vitally important to our nation, as a reflection of the health of a large portion of our population and as an indicator of the health status of the next generation. Infant mortality, the death of an infant less than one year old, is an important measure of a nation's health, and also serves as a global indicator of health status and social well being. In 1995, the United States infant mortality rate placed it 25th among industrialized nations.

Five causes account for more than half of all infant deaths: birth defects, disorders associated with short gestation and unspecified low birth weight, sudden infant death syndrome, respiratory distress syndrome, and maternal complications of birth. Maternal age is also a risk factor for infant death. Mortality rates are highest for infants born to young teenagers (aged 16 years and under) and to mothers aged 44 years and older.

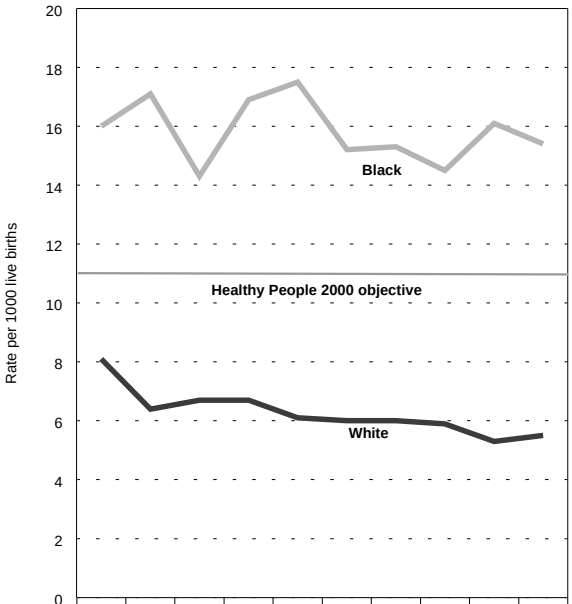
Infant Mortality Rate, Maryland and the United States, 1989-1998.



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Maryland	10.4	9.6	9.1	9.8	9.8	8.8	8.7	8.4	8.6	8.6
U.S.	9.8	9.2	8.9	8.5	8.3	8	7.6	7.3	7.2	7.2

Source: Maryland Vital Statistics, 1998 Annual Report and National Vital Statistics System (NVSS), CDC, NCHNCHS, 1998.

Infant Mortality Rate by Race, Maryland, 1989-1998.



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
White	8.1	6.4	6.7	6.7	6.1	6	6	5.9	5.3	5.5
Black	16	17.1	14.3	16.9	17.5	15.2	15.3	14.5	16.1	15.4

Source: Maryland Vital Statistics, 1998 Annual Report.

Over the past ten years, the infant mortality rate (IMR) in Maryland has generally declined, reaching an all time low of 8.4 deaths per 1,000 live births in 1996. Unfortunately, in 1997, the IMR did increase slightly to 8.6 deaths per 1,000 live births and remained there in 1998. The IMR in Maryland has consistently been higher than that of the United States. The 1998 Maryland IMR also falls short of the Healthy People 2000 goal of 7.0 infant deaths per 1,000 live births. The Healthy People 2010 goal calls for a reduction of infant deaths to 4.5 per 1,000, an even more far-reaching goal.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Reducing Infant Mortality*
Charles County - *Maternal and Infant Mortality*,
Montgomery County - *Reducing African American Infant Mortality*
Prince George's County - *Reducing Infant Mortality in Prince George's County*

Priority focus in other jurisdictions

Maternal and infant health is included as a priority area for FY2000 in:
Anne Arundel County • Baltimore County • Dorchester County • St. Mary's County
Washington County • Wicomico County • Worcester County

Highlights of HIP strategies recommended to improve maternal and infant health
(for in-depth details, see the complete text of each state and county module)

- Reduce the infant mortality rates among the general and the African-American populations. (**State**)
- Reduce the incidence of low birth weight. (**State** and **Charles County**)
- Engage the community in reducing African-American infant mortality. (**Montgomery County**)
- Work with the Healthy Families Program to provide intensive support to first time mothers and with the Teen Pregnancy Home Visiting Program to educate teen mothers about the developmental needs of their children. (**Charles County**)
- Increase the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy. (**Charles and Prince George's Counties**)
- Determine the capacity among health care providers to provide culturally and linguistically competent pre-conception, prenatal, and post-natal care to the County's diverse populations. (**Prince George's County**)

Statewide Partners

Center for Maternal and Child Health, DHMH • Governor's Office for Children, Youth, and Families • Johns Hopkins University • Planned Parenthood of Maryland, Inc. • University of Maryland, Baltimore County

MENTAL HEALTH

The Issue

Mental health is vital to the productive and happy life of every individual. The availability of needed mental health services, particularly those in the public mental health system, are critical for treatment of mental disorders among affected Maryland residents.

Mental Health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity. Mental Illness is the term that refers collectively to all diagnosable mental disorders. These health conditions are characterized by alterations in thinking, mood, or behavior, which can be associated with distress and impaired functioning.

> ***Mental disorders generate an enormous public health burden. Four of the ten leading causes of disability for persons, ages 5 and older, are mental disorders. In developed nations, including the United States, major depression is the leading cause of disability.***
> World Health Organization and the World Bank, "Global Burden of Disease," 1996

Mental disorders can occur across the lifespan, affecting all racial and ethnic groups, both sexes, and all educational and socioeconomic groups. According the National Institutes of Mental Health, approximately 40 million Americans, aged 18 to 64 years, or 22 percent of the population, had a diagnosis of mental disorder alone (19%), or of a co-occuring mental and addictive disorder (3%) in the past year (1999).

Mental disorders are real health conditions that have an immense impact on individuals and families. Treatment and mental health services are critical to Maryland's health. Currently, approximately 75,000 individuals, whose psychiatric conditions meet criteria for medically necessary services, receive intervention, treatment, and support services through the Public Mental Health System (PMHS) in Maryland.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Development of a Statewide Comprehensive Crisis Services System*; *Improving the Public Mental Health System*, and; *Treating Recognized Depression*
Worcester County - *Access to Quality Mental Health Services in Worcester County*

Priority focus in other jurisdictions

Mental health is included as a priority area for FY2000 in:

Allegany County • Carroll County • Charles County • Frederick County
Harford County • Prince George's County • Talbot County
Washington County • Worcester County

Highlights of HIP strategies recommended to improve mental health

(for in-depth details, see the complete text of each state and county module)

- Develop a Statewide Comprehensive Crisis Services System, with private and public resources, to promote and improve mental health status. (**State**)
- Increase the proportion of consumers of Public Mental Health Services who indicate they are satisfied with the choice of providers and services they receive. (**State**)
- Increase the proportion of children and young adults with co-occurring substance abuse and mental disorders who receive treatment for both disorders. (**Worcester County**)
- Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems. (**Worcester County**)

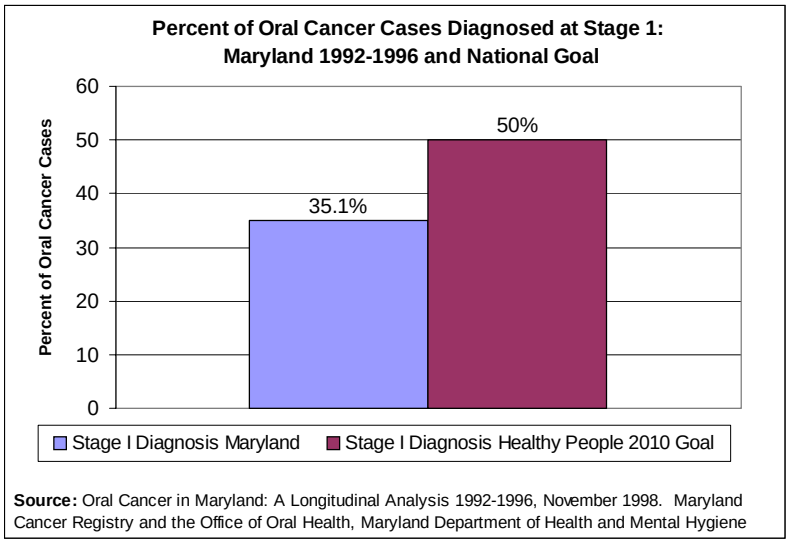
Statewide Partners

Maryland Health Partners • Maryland Local Advocacy Organizations • Maryland Local Core Service Agencies • Maryland Local Health Departments • Maryland Local Hospitals and Mental Health Providers • Maryland Local Police and Public Safety • Maryland Mental Hygiene Administration, DHMH

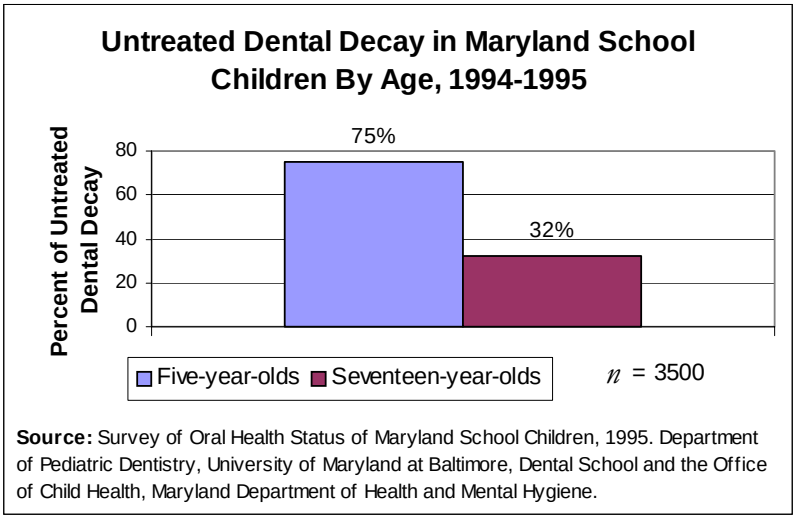
ORAL HEALTH

The Issue

Good oral health involves more than healthy teeth. Lack of oral health has major consequences for children and adults. Available evidence indicates that the impact of oral disease, one of the most preventable health problems, is greatly felt, especially among Maryland's children.



Source: Oral Cancer in Maryland: A Longitudinal Analysis 1992-1996, November 1998. Maryland Cancer Registry and the Office of Oral Health, Maryland Department of Health and Mental Hygiene



Source: Survey of Oral Health Status of Maryland School Children, 1995. Department of Pediatric Dentistry, University of Maryland at Baltimore, Dental School and the Office of Child Health, Maryland Department of Health and Mental Hygiene.

Oral health means much more than healthy teeth. It means being free of chronic conditions, oral and pharyngeal cancers, tooth decay, periodontal disease, broken teeth or jaws, as well as the absence of developmental and congenital conditions such as cleft lip and palate. Oral health is integral to general health. Lack of proper oral health has major consequences for children and adults. Oral health problems developed in childhood can lead to lifelong oral and even systemic complications. Maryland ranks seventh among the states in oral cancer mortality.

Oral disease has been recognized as one of the most preventable diseases, but also, one of the most prevalent diseases among young people. In the United States, 25% of children and adolescents experience 80% of all dental decay. Children whose families have low incomes, are in minority groups, have minimal exposure to fluoride, have special health needs or come from less educated or poorer families are at greatest risk for oral disease. In 1995, fewer than one in five children in the United States who were eligible for dental services under the Medicaid Early and Periodic Screening, Diagnostic and Treatment Program received a preventive screening.

The oral health status of children in Maryland mirrors that of the nation. In 1993, only 14.2% of Medicaid-eligible children in Maryland received Early and Periodic Screening, Diagnostic and Treatment. The Survey of the Oral Health Status of Maryland School Children, 1994-1995, found three times the U.S. average in untreated tooth decay in Maryland children. Seventy-five percent

of this untreated decay was found in 5-year-olds versus 32% of untreated decay found in 17-year-olds. Children living in areas without fluoridated water had 50% more decayed teeth than children living in areas with fluoridated water. The impact of poor oral health to all Marylanders, especially our children, is great.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Reducing Oral Cancer Mortality* and *Preventing Oral Disease in Children*
Allegany County - *Oral Health*
Carroll County - *Improving Access to Oral Health Services*
Frederick County - *Developing a Support System to Improve the Dental Health of Frederick County Children*
Garrett County - *Improving the Dental Status of Children*
St. Mary's County - *Promoting Oral Health*

Priority focus in other jurisdictions

Oral health is included as a priority area for FY2000 in:
Montgomery County • Talbot County • Washington County

Highlights of HIP strategies recommended to improve oral health
(for in-depth details, see the complete text of each state and county module)

- Increase the early detection of oropharyngeal cancer lesions. (**State**)
- Increase dental access for individuals receiving Medical Assistance. (**State**)
- Increase dental sealant use among children in Allegany County. (**Allegany County**)
- Reduce the proportion of school-age children in Carroll County with dental caries. (**Carroll County**)
- Increase service provision for children of the medical assistance population. (**Frederick County**)
- Decrease untreated dental decay among kindergarten children. (**Garrett County**)
- Develop a primary prevention program. (**St. Mary's County**)

Statewide Partners

Advocates for Children and Youth • Center for Cancer Control and Surveillance, DHMH • Centers for Disease Control and Prevention • Head Start • Managed Care Organizations participating in HealthChoice • Maryland Academy of Pediatric Dentistry • Maryland Chapter of the American Cancer Society • Maryland Dental Hygienist's Association • Maryland Dental Society • Maryland Medicaid • Maryland Office of Children, Youth and Families • Maryland State Dental Association • Maryland State Women, Infant, and Children (WIC) Program, DHMH • National Institute for Dental and Craniofacial Research • Office of Child Health, DHMH • Office of Oral Health, DHMH • University of Maryland Dental School

PUBLIC HEALTH INFRASTRUCTURE

The Issue

The public health infrastructure - the professional workforce, information and data systems, health departments, and laboratories - are Maryland's first line of defense against a wide range of real and potential health threats. Maintenance of an adequate level of readiness is essential for daily new and on going threats to the public's health.

Our national public health infrastructure is the first, and in many cases, the only line of defense against a barrage of real and potential health threats. Combating the spread of disease and constant environmental and occupational hazards requires a consistent state of readiness. We face the daily presence of new and old microbes in forms of West Nile virus, the increase in multi-drug resistant tuberculosis and staphylococcus infections, and ever increasing chronic diseases, such as diabetes, heart disease, and cancers. Even more frightening is the potential for intentional threats to our public health, in the form of the death and destruction that can be caused by bioterrorism with the willful release of infectious agents into whole populations.

Our public health system--the professional workforce, information and data systems, health departments, and laboratories--must be able to sustain ongoing preparedness and vigilance to meet the growing demands of global health threats. At the same time that new technologies have improved transportation and increased the risk of spreading diseases faster, new technologies have also increased our ability to share information and data about those diseases faster than ever before. A 2000 report by the Centers for Disease Control and Prevention on the nation's public health infrastructure identified gaps in: workforce capacity and competency, information and data systems, and organizational capacities of local and state health departments and laboratories.

The principal public health agencies in Maryland are the State and local health departments. Many additional public and private entities are also involved in providing for the health of all Marylanders. In order to carry out the programs proposed in the Maryland Health Improvement Plan, Maryland's public health infrastructure must identify its weaknesses, build on its strengths and plan for its future capacity. The question becomes, "How will we shape and sustain the public health infrastructure to meet the needs of the 21st century?"

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Improving Access to Health Data* and *Ensuring an Adequate Public Health Workforce*
Harford County - *Public Health Infrastructure*
Prince George's County - *Enhancing Infrastructure for Health Planning*

Priority focus in other jurisdictions

Public health infrastructure is included as a priority area for FY2000 in:
Frederick County • Harford County • Worcester County

Highlights of HIP strategies recommended to improve the public health infrastructure
(for in-depth details, see the complete text of each state and county module)

- Establish the capacity to monitor and plan for statewide need for public health workers. (**State**)
- Expand the existence and use of distance learning technologies at State and local health departments. (**State**)
- Develop a Report Card of the county's progress to date toward reaching its health care goals. (**Harford County**)
- Complete a formal county-wide needs assessment and establish an on-going needs assessment process through which local health needs and priorities are identified and reflected in the local health improvement plan. (**Prince George's County**)

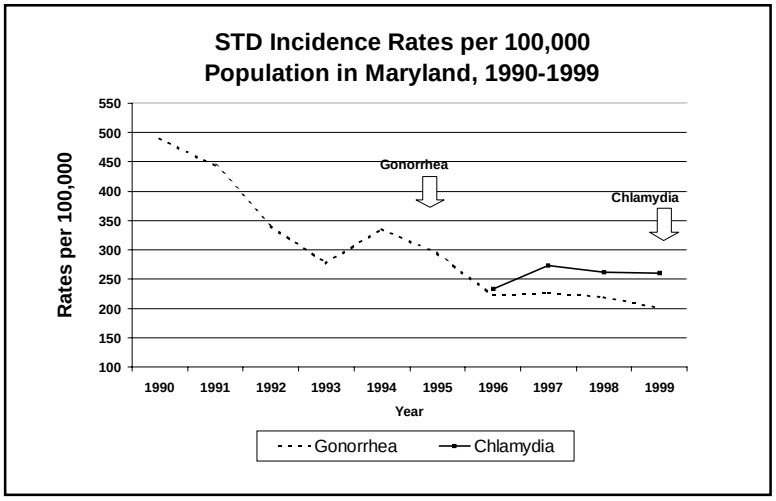
Statewide Partners

Information Resources Management Administration, DHMH • Maryland Association of County Health Officers • Maryland Department of Budget Management, Personnel Division • Maryland Department of Health and Mental Hygiene (DHMH) • Maryland Local Health Departments • Maryland Public Health Association • Office of Health Policy, DHMH • Office of Public Health Assessment, DHMH

SEXUALLY TRANSMITTED DISEASES

The Issue

The impact of sexually transmitted diseases varies around the State and among different population groups - with women, adolescents, and African-Americans being disproportionately affected. Control of these diseases, which are among the most widespread, least detected, and costly of the infectious diseases, is essential for Maryland's public health.

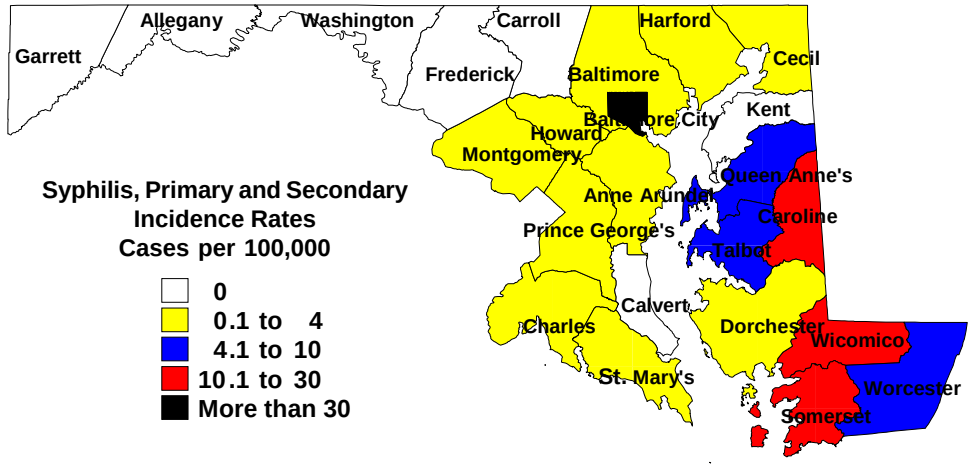


Source: Maryland DHMH Center for Community Epidemiology, 2000

Sexually transmitted diseases (STDs) are among the most widespread, least detected, and costly infectious diseases reported throughout the world today. STDs (syphilis, gonorrhea, chlamydia, hepatitis B and human papilloma virus, in particular) have long been a significant public health problem. STDs can cause many harmful, often irreversible, and costly clinical complications, including reproductive health problems, fetal and perinatal health problems, and cancer.

Maryland experienced downward trends in the case numbers and rates of STDs in the early 1990s. However, in 1997, Maryland's rate of infectious syphilis was the highest in the nation. Additionally, Maryland's reported rate of gonorrhea infections was almost double the comparable national rate for 1998. While the impact of STDs varies across the State and among different population groups (with women, adolescents, African-Americans and other minorities disproportionately affected), STDs are a continuing public health concern to all residents of Maryland.

Primary and Secondary Syphilis in Maryland, 1999



Source: Epidemiology and Disease Control Program, DHMH, 1999

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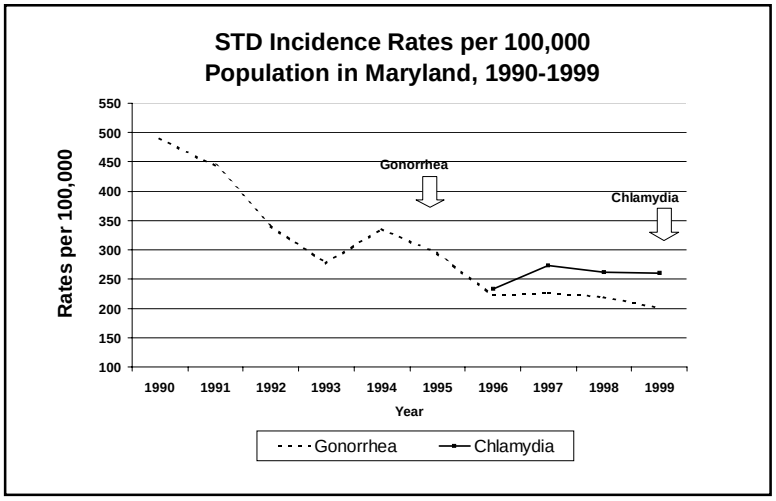

Source: Maryland DHMH Center for Community Epidemiology, 2000

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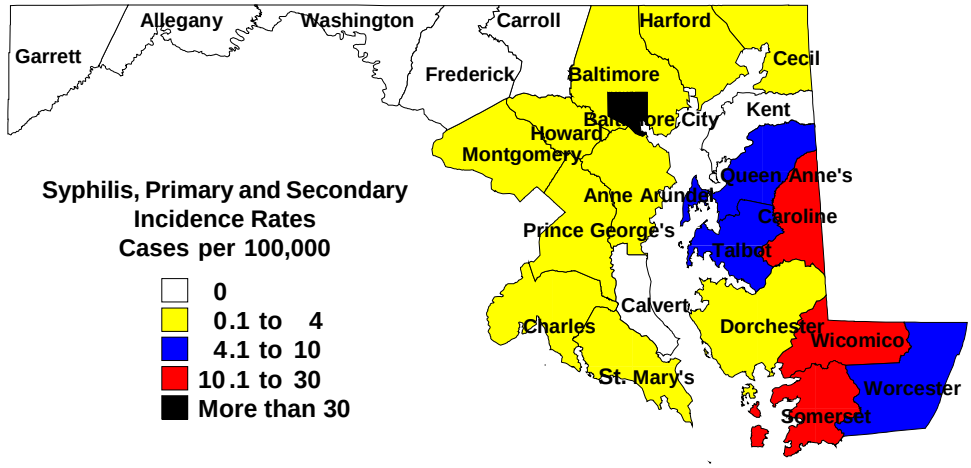

Source: Epidemiology and Disease Control Program, DHMH, 1999

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Preventing Sexually Transmitted Diseases*
Caroline County - *Control of Sexually Transmitted Diseases Among the Adolescent Population of Caroline County*
Kent County - *Reducing Sexually Transmitted Disease Rates in Kent County*

Priority focus in other jurisdictions

STDs is included as a priority area for FY2000 in:

Allegany County • Anne Arundel County • Caroline County • Cecil County
Dorchester County • Harford County • Kent County • Prince George's County
Worcester County • Baltimore City

Highlights of HIP strategies recommended to decrease STDs

(for in-depth details, see the complete text of each state and county module)

- Reduce the rates of gonorrhea and syphilis. (**State**)
- Reduce the rates of chlamydia. (**State, Caroline and Kent counties**)
- Promote rapid identification and follow-up of persons with STDs to assure adequate treatment, education, and partner counseling. (**State**)
- Build the public health infrastructure to eliminate STD in accordance with the Centers for Disease Control and Prevention (CDC) recommendations. (**State**)
- Educate nurses and private physicians about the importance of case reporting, treatment, and contact tracing. (**Caroline County**)
- Provide informational pamphlets in the health suites of county middle schools and high schools. (**Kent County**).

Statewide Partners

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SUBSTANCE ABUSE

The Issue

Substance abuse, which affects all racial, cultural, and economic groups, greatly impacts the quality of life of a growing number of children who may suffer abuse and neglect at the hands of an addicted parent. The gap between available treatment slots and the number of people seeking treatment for illicit drug use and alcohol abuse is a continuing problem in Maryland.

Substance abuse refers to overuse of, and chronic addiction to alcohol and/or other drugs, especially illegal drugs. Substance abuse is an issue that affects all racial, cultural, and economic groups, at the national, state, and local levels. According to the National Institutes of Health in 1995, the economic cost of alcohol and drug abuse represents more than $1,000 for every man, woman, and child in the United States for the cost of health care, motor vehicle crashes, crime, lost productivity, and other adverse outcomes of alcohol and drug abuse.

Substance abuse greatly impacts the quality of life for a growing number of children who may suffer abuse and neglect at the hands of an addicted parent. According to the Maryland's Children Action Network, 60 percent of children in out-of-home placement in 1998 had a parent with identified substance abuse problems. Other research shows that children who live in a house with an addicted parent are more likely to become drug and alcohol users as they grow up.

Routinely, publicly-funded treatment programs in the State are filled to capacity. Many clients seeking treatment (especially those who are uninsured or underinsured) are unable to access the full range of services necessary for recovery. The Maryland Alcohol and Drug Abuse

Maryland Alcohol and Drug Abuse Treatment Need by Region, FY 1997

Counties	Treatment Need	ADAA Funded Slots
Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties	66,543	5,051
Montgomery, and Prince George's Counties	34,741	2,261
Calvert, Charles, and St. Mary's Counties	13,985	1,309
Allegany, Frederick, Garrett, and Washington Counties	18,346	1,484
Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties	23,807	1,894
City of Baltimore	60,928	5,709
Statewide	**218,350**	**17,708**

Source: Alcohol and Drug Abuse Administration, February 1998

Administration (ADAA) reports that statewide, several thousand people are turned away from treatment programs every month. ADAA Prevalence Estimates for 1998 indicate a need statewide for over 200,000 treatment slots. The gap between available treatment slots and the number of people seeking treatment for illicit drug use and alcohol abuse is a continuing problem.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Increasing Substance Abuse Treatment*.
Carroll County - *Reduction of Substance Abuse*
Harford County - *Substance Abuse Treatment*
Queen Anne's County - *Preventing Alcohol and Drug Use in the Population Less Than 21 Years Old*
Wicomico County - *Reducing Underage Drinking*

Priority focus in other jurisdictions

Substance abuse is included as a priority area for FY2000 in:
Allegany County • Anne Arundel County • Calvert County • Carroll County
Charles County • Harford County • Montgomery County • Prince George's County
Talbot County • Washington County • Wicomico County • Worcester County
Baltimore City

Highlights of HIP strategies recommended to decrease substance abuse
(for in-depth details, see the complete text of each state and county module)

- Decrease the number of people on waiting lists to receive substance abuse treatment by providing more treatment availability. (**State**)
- Provide/increase access to substance abuse treatment (**Carroll and Harford counties**) for the growing numbers of uninsured and underinsured in each jurisdiction. (**State**)
- Complete a comprehensive needs assessment (**State**) to prioritize needs. (**Carroll County**)
- Develop and implement a county wide Substance Abuse Data Information System for all public and private treatment program clients. (**Harford County**)
- Decrease adolescents' perceptions that parents accept underage drinking and drug use as a norm. (**Queen Anne's County**)
- Develop and implement comprehensive media campaigns targeting population groups at high risk for substance abuse. (**Wicomico County**)

Statewide Partners

Alcohol and Drug Abuse Administration, DHMH • Maryland Department of Health and Mental Hygiene (DHMH) • Maryland Department of Juvenile Justice • Maryland Department of Social Services • Maryland Local Health Departments • Maryland Office of the State's Attorney • State of Maryland Task Force to Study Increasing the Availability of Substance Abuse Programs

TOBACCO USE

The Issue

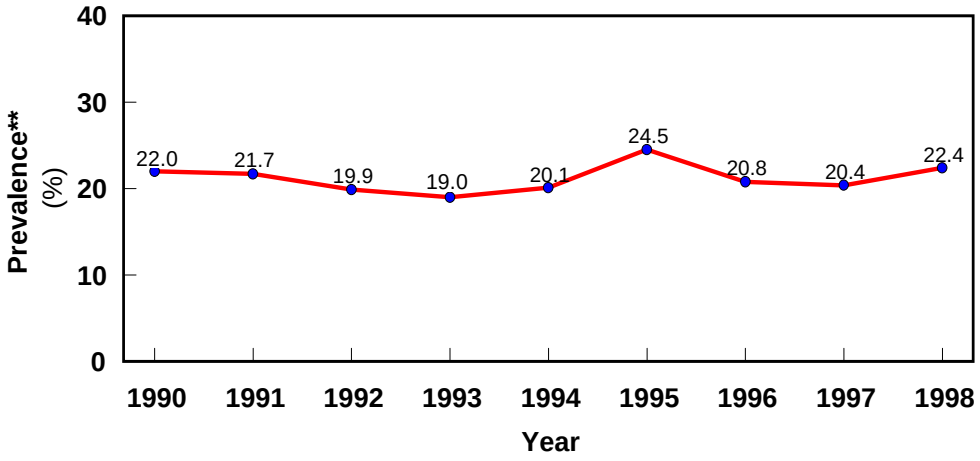
Tobacco use is the single, largest cause of preventable deaths, estimated at 7,500 every year in Maryland. Use of the State's portion of the proceeds from the Master Settlement Agreement with the tobacco industry provides a historic opportunity for Maryland to address cancer and other health problems associated with tobacco use among its residents.

Tobacco use is the single largest cause of preventable death every year in the United States and in Maryland. This one risk behavior kills more Americans than motor vehicle crashes, AIDS, cocaine use, heroin use, homicide and suicide combined. Although most commonly associated with cancers, tobacco is a risk factor in many other diseases and conditions. Tobacco use costs the United States almost $1 billion every week in medical expenses alone. This does not include loss of income due to illness and premature death.

Despite these alarming statistics, each day, more than 6,000 young people try a cigarette, and nearly 3,000 become daily smokers--a total of more than one million new smokers each year. The tobacco industry currently invests in excess of $6 billion annually to promote the use of its products in the United States alone.

Tobacco-related disease is estimated to result in the premature death of 7,500 Marylanders each year. In the Fall of 1998, Maryland joined in a Master Settlement Agreement to settle the

Current Smokers* Among Maryland Adults Age 18 and Over, 1990-1998



*Current smokers is defined as respondents who have smoked at least 100 cigarettes in their lifetime and now smoke everyday or somedays
**Prevalence estimates were weighted to the Maryland census population; Respondents who answered "Don't know" or "Refused" were excluded from the denominator.

Source: Maryland Behavioral Risk Factor Surveillance System

states' lawsuits against the tobacco industry. Under terms of that settlement, Maryland will receive an estimated $4.2 billion over the next 25 years, deposited to the Cigarette Restitution Fund (CRF). The CRF is a special fund from which the Maryland General Assembly may appropriate funding for programs dedicated to tobacco use prevention, cancer, or any other public purpose.

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Reducing the Use of Tobacco Products*
Dorchester County - *Tobacco Cessation: Young Adults*, and *Tobacco Use Prevention*
Somerset County - *Reducing Tobacco Use Among Youth*

Priority focus in other jurisdictions

Tobacco use is included as a priority area for FY 2000 in:
Allegany County • Anne Arundel County • Calvert County • Cecil County Garrett County • Harford County • Washington County • Wicomico County Worcester County

Highlights of HIP strategies recommended to decrease tobacco use
(for in-depth details, see the complete text of each state and county module)

- Reduce tobacco use among Maryland adults, school age youth (**Somerset County**), pregnant women (**State**), and young adults (**Dorchester County**).
- Decrease the number of children exposed to secondhand smoke (**State**) at home (**Dorchester County**).
- Increase the number of primary care providers who support smoking cessation for their patients who smoke. (**State**)
- Develop tailored smoking cessation strategies for high-risk population groups. (**Dorchester County**)
- Support community groups on their efforts to prevent smoking among adolescents. (**Somerset County**)

Statewide Partners

Maryland Department of Health and Mental Hygiene (DHMH) • Maryland Local Health Departments • Office of Health Promotion, Education, and Tobacco Use Prevention, DHMH • Supporters of the Task Force to End Smoking in Maryland

Topics, by jurisdiction, included in the Health Improvement Plan

Statewide - *Preventing Sexually Transmitted Diseases*
Caroline County - *Control of Sexually Transmitted Diseases Among the Adolescent Population of Caroline County*
Kent County - *Reducing Sexually Transmitted Disease Rates in Kent County*

Priority focus in other jurisdictions

STDs is included as a priority area for FY2000 in:

Allegany County • Anne Arundel County • Caroline County • Cecil County
Dorchester County • Harford County • Kent County • Prince George's County
Worcester County • Baltimore City

Highlights of HIP strategies recommended to decrease STDs

(for in-depth details, see the complete text of each state and county module)

- Reduce the rates of gonorrhea and syphilis. (**State**)
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- Promote rapid identification and follow-up of persons with STDs to assure adequate treatment, education, and partner counseling. (**State**)
- Build the public health infrastructure to eliminate STD in accordance with the Centers for Disease Control and Prevention (CDC) recommendations. (**State**)
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- Provide informational pamphlets in the health suites of county middle schools and high schools. (**Kent County**).

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III. APPENDIX

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